96-195

VARIOUS MEDICAID PROPOSALS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

H.R. 7028, H.R. 7029, H.R. 7030, H.R. 7031, AND H.R. 7468

BILLS THAT PROPOSE FUNDAMENTAL CHANGES IN THE MEDICAID PROGRAM, WITH MAJOR IMPLICATIONS FOR PROGRAM ELIGIBLES, PARTICIPATING PROVIDERS, AND FOR FEDERAL AND STATE GOVERNMENT

NEWARK PUBLIC LIBRARY

SEPTEMBER 8, 1980

DEC 18 1980

Serial No. 96-195

U. S. GOVT. PUBS.
DEPOSITORY 376

Printed for the use of the
Committee on Interstate and Foreign Commerce

U.S. GOVERNMENT PRINTING OFFICE
66-669 O WASHINGTON : 1980

Y 4.In 8/4:

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HARLEY O. STAGGERS, West Virginia, *Chairman*

JOHN C. DINGELL, Michigan
LIONEL VAN DEERLIN, California
JOHN M. MURPHY, New York
DAVID E. SATTERFIELD III, Virginia
BOB ECKHARDT, Texas
RICHARDSON PREYER, North Carolina
JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
JIM SANTINI, Nevada
ANDREW MAGUIRE, New Jersey
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
ALBERT GORE, Jr., Tennessee
BARBARA A. MIKULSKI, Maryland
RONALD M. MOTTL, Ohio
PHIL GRAMM, Texas
AL SWIFT, Washington
MICKEY LELAND, Texas
RICHARD C. SHELBY, Alabama
ROBERT T. MATSUI, California

JAMES T. BROYHILL, North Carolina
SAMUEL L. DEVINE, Ohio
TIM LEE CARTER, Kentucky
CLARENCE J. BROWN, Ohio
JAMES M. COLLINS, Texas
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
DAVE STOCKMAN, Michigan
MARC L. MARKS, Pennsylvania
TOM CORCORAN, Illinois
GARY A. LEE, New York
TOM LOEFFLER, Texas
WILLIAM E. DANNEMEYER, California

KENNETH J. PAINTER, *Chief Clerk and Staff Director*
ELEANOR A. DINKINS, *First Assistant Clerk*
KAREN NELSON, *Professional Staff*
ROBERT H. LAMB, *Associate Minority Counsel*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HENRY A. WAXMAN, California, *Chairman*

DAVID E. SATTERFIELD III, Virginia
RICHARDSON PREYER, North Carolina
ANDREW MAGUIRE, New Jersey
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BARBARA A. MIKULSKI, Maryland
PHIL GRAMM, Texas
MICKEY LELAND, Texas
RICHARD C. SHELBY, Alabama
JOHN M. MURPHY, New York
HARLEY O. STAGGERS, West Virginia
(Ex Officio)

TIM LEE CARTER, Kentucky
SAMUEL L. DEVINE, Ohio
DAVE STOCKMAN, Michigan
WILLIAM E. DANNEMEYER, California
GARY A. LEE, New York
JAMES T. BROYHILL, North Carolina
(Ex Officio)

MARGERY COLLOFF, *Staff Director*
ANDREAS G. SCHNEIDER, *Assistant Counsel*
DAVIS S. ABERNETHY, *Minority Staff Assistant*

CONTENTS

Page

Text of—
- H.R. 7028 ... 3
- H.R. 7029 ... 5
- H.R. 7030 ... 7
- H.R. 7031 ... 9
- H.R. 7468 ... 11

Statement of—
- Bennett, LaNita A., parlegal, Legal Services Corp. of Alabama ... 81, 120
- Bevill, Hon. Tom, a Representative in Congress from the State of Alabama ... 13
- Brown, Mildred, Anniston, Ala ... 87, 161
- Davis, Karen, Ph. D., Deputy Assistant for Planning and Evaluation/Health, Department of Health and Human Services ... 46
- Edelman, Toby, staff counsel, National Senior Citizens Law Center ... 81, 171
- Gordon, Spiver W., board member, Southern Christian Leadership Conference ... 87, 161
- Hamburger, Betty K., on behalf of National Citizens Coalition for Nursing Home Reform ... 87, 163
- Harrison, James, Jr., member, board of directors, Nation Association of Chain Drug Stores ... 179, 190
- Heflin, Hon. Howell, a U.S. Senator from the State of Alabama ... 13
- Kerns, W. H., commissioner, Medical Services Administration, State of Alabama ... 15
- Owens, Walter, chairman, Ways and Means, Alabama House of Representatives ... 15, 24
- Pegues, R. Leigh, Alabama House of Representatives ... 15, 29
- Tucker, John B., Jr., R. Ph., director, government affairs, National Association of Retail Druggists ... 179
- Waxman, Judith G., on behalf of National Health Law Program, Inc ... 87
- White, Dewey, Jr., M.D., chairman, Health and Welfare Committee, Alabama State Senate ... 15, 25
- Willging, Paul, Ph. D., Bureau of Program Operations, Health Care Financing Administration, Public Health Service, Department of Health and Human Services ... 46

Additional material submitted for the record by—
- Health and Human Services Department, Actions (allowable under current law, regulations, and practice) that Alabama could pursue to contain costs ... 75
- Legal Services Corp. of Alabama, attachments to Ms. Bennett's prepared statement:
  - Affidavits on behalf of Alabama medicaid recipients ... 125
  - Article—medicaid difference between having and doing without for many Alabamians ... 124
- National Health Law Program, Inc., attachments to Ms. Waxman's prepared statement:
  - Copayments for ambulatory care: Pennywise and pound-foolish ... 110
  - Letter, dated July 22, 1980, from Dr. Roemer to Michael Parks re H.R. 7029 which would amend Social Security Act title XIX, to permit State medicaid programs to require "nominal copayments for basic services provided to categorically needy individuals" ... 107
  - National Senior Citizens Law Center ... 171

Page

Statements submitted for the record by—
American Hospital Association 195
American Pharmaceutical Association 199
Letter submitted for the record by—
American Dental Association, Wilfred A. Springer, D.D.S., chairman, council on legislation 204

READEX FICHE best copy available

VARIOUS MEDICAID PROPOSALS

MONDAY, SEPTEMBER 8, 1980

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. WAXMAN. The subcommittee will come to order.

This morning the subcommittee will hear testimony on five measures introduced by our colleague, Congressman Shelby, H.R. 7028, H.R. 7029, H.R. 7030, H.R. 7031, and H.R. 7468. These bills propose fundamental changes in the medicaid program, changes with major implications for program eligibles, for participating providers and for Federal and State Government alike.

The purpose of this hearing is to examine the implications of these bills for the medicaid program and those directly affected by it.

I want to recognize, our distinguished colleague from Alabama, who has exercised leadership in proposing these bills to deal with the very serious problem in his State and others meeting the financial needs of the medicaid program.

I would like to call on Congressman Shelby.

Mr. SHELBY. Thank you, Mr. Chairman.

First of all, I want to thank the chairman for scheduling these hearings. These bills were introduced late in the year as far as the legislative session is concerned. He has scheduled them and rescheduled them three times already, and I want to thank him for this.

I want to thank you again, Mr. Chairman, for allowing us the opportunity from Alabama to present the problems facing us and some of the solutions that some of the people back home who are dealing in the problems everyday are experiencing, and some of the ideas they have as far as trying to seek a resolution to the crisis.

We have had a real crisis in the medicaid program in Alabama and, of course, a lot of it is lack of funding from the State level. But I experienced firsthand during my 8 years in the Alabama Senate some of it, and we have seen it grow by leaps and bounds. We have got some real problems and this is an opportunity for your people today.

I also want to first recognize my distinguished colleague, Tom Bevill, who is a member of the Approporiations Committee and chairman of the Subcommittee on Energy and Water in the House Appropriations Committee here today.

Tom, if you would go ahead and say what you want to.

Mr. WAXMAN. I would like, without objection, to have the text of H.R. 7028, H.R. 7029, H.R. 7030, H.R. 7031, and H.R. 7468 printed in the record at this point.

[Testimony resumes on p. 13.]

The text of H.R. 7028, H.R. 7029, H.R. 7031, and H.R. 7468 follow:]

96TH CONGRESS
2D SESSION

H. R. 7028

To permit relatives of medicaid eligible individuals residing in nursing homes to contribute voluntarily to a State fund for the provision of such care.

IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 1980

Mr. SHELBY (for himself, Mr. BEVILL, Mr. FLIPPO, Mr. NICHOLS, Mr. BUCHANAN, Mr. DICKINSON, and Mr. EDWARDS of Alabama) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

---

A BILL

To permit relatives of Medicaid eligible individuals residing in nursing homes to contribute voluntarily to a State fund for the provision of such care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That nothing in title XIX of the Social Security Act shall be construed to prohibit a State (as defined for purposes of such title) from establishing a program under which persons, who are related to individuals receiving skilled nursing facility or intermediate care facility services for which medical assist-

ance is provided under the State's plan approved under that title, may contribute voluntarily to a fund which is used for the provision of medical assistance with respect to skilled nursing facility and intermediate care facility services covered under such plan.

○

I

96TH CONGRESS
2D SESSION

H. R. 7029

To amend title XIX of the Social Security Act to permit State medicaid programs to require nominal copayments for basic services provided to categorically needy individuals.

IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 1980

Mr. SHELBY (for himself, Mr. BEVILL, Mr. FLIPPO, Mr. NICHOLS, Mr. BUCHANAN, Mr. DICKINSON, and Mr. EDWARDS of Alabama) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

---

A BILL

To amend title XIX of the Social Security Act to permit State medicaid programs to require nominal copayments for basic services provided to categorically needy individuals.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 1902(a)(14)(A) of the Social Security Act (42 U.S.C. 1396a(a)(14)(A)) is amended—

(1) by striking out ", and no deduction, cost sharing, or similar charge with respect to the care and

services listed in clauses (1) through (5) and (7) of section 1905(a)," in clause (i), and

(2) by striking out "with respect to other care and services" in clause (ii).

SEC. 2. The amendments made by the first section of this Act shall take effect on the first day of the first calendar quarter beginning after the date of the enactment of this Act.

O

96TH CONGRESS
2D SESSION

H. R. 7030

To amend title XIX of the Social Security Act to permit States to terminate eligibility for medicaid medical assistance for up to one year for individuals determined to have abused the medicaid program.

IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 1980

Mr. SHELBY (for himself, Mr. BEVILL, Mr. FLIPPO, Mr. NICHOLS, Mr. BUCHANAN, Mr. DICKINSON, and Mr. EDWARDS of Alabama) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

---

A BILL

To amend title XIX of the Social Security Act to permit States to terminate eligibility for medicaid medical assistance for up to one year for individuals determined to have abused the medicaid program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the second sentence of section 1909(a) of the Social Security Act (42 U.S.C. 1396h(a)) is amended—

(1) by inserting "either" before "is convicted of an offense", and

(2) by inserting "or, after notice and opportunity for a hearing, is determined (by a preponderance of the evidence) to have committed an act described in paragraph (1), (2), (3), or (4) of this subsection" after "under the preceding provisions of this subsection".

SEC. 2. The amendments made by the first section of this Act shall apply to acts committed on or after the date of the enactment of this Act.

○

96TH CONGRESS
2D SESSION

H. R. 7031

To amend title XIX of the Social Security Act to allow States to provide for competitive bidding for the purchase of certain items under their medicaid plans.

IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 1980

Mr. SHELBY (for himself, Mr. BEVILL, Mr. FLIPPO, Mr. NICHOLS, Mr. BUCHANAN, Mr. DICKINSON, and Mr. EDWARDS of Alabama) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

---

A BILL

To amend title XIX of the Social Security Act to allow States to provide for competitive bidding for the purchase of certain items under their medicaid plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a(a)(23)) is amended by inserting "(A)" before "has entered into" and by inserting before the semicolon at the end the following: ", or (B) has made arrangements through a competitive bidding process or otherwise for the

purchase of (at the election of the State) laboratory and X-ray services (referred to in section 1905(a)(3)), family planning supplies (referred to in section 1905(a)(4)(C)), or prescription drugs, dentures, prosthetic devices, or eyeglasses (referred to in section 1905(a)(12)), if the Secretary has found that (i) adequate services will be available under such arrangements, (ii) the providers of such services meet the requirements otherwise imposed for the provision of such services under the plan, and (iii) charges for such services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services".

SEC. 2. The amendments made by the first section of this Act shall take effect on the first day of the first calendar quarter beginning after the date of the enactment of this Act.

O

I

96TH CONGRESS
2D SESSION

H. R. 7468

To amend title XIX of the Social Security Act to provide that the Federal medical assistance percentage will be 100 per centum for individuals during periods in which they have been incorrectly certified as supplemental security income recipients, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 29, 1980

Mr. SHELBY (for himself, Mr. FLIPPO, Mr. NICHOLS, Mr. BEVILL, Mr. BUCHANAN, Mr. EDWARDS of Alabama, and Mr. DICKINSON) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

---

A BILL

To amend title XIX of the Social Security Act to provide that the Federal medical assistance percentage will be 100 per centum for individuals during periods in which they have been incorrectly certified as supplemental security income recipients, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking out "and" before "(2)", and

(2) by inserting before the period at the end the following: ", and (3) notwithstanding clause (1), the Federal medical assistance percentage shall be 100 per centum with respect to medical assistance provided to individuals during any period in which their eligibility for assistance under the plan was established on the basis of an incorrect determination by the Secretary of their entitlement to have supplemental security income benefits paid with respect to them under title XVI".

(b) In the case of any individual in a State (as defined for purposes of title XIX of the Social Security Act) with respect to whom supplemental security income benefits have been paid under title XVI of such Act but are subsequently terminated, the Secretary of Health and Human Services shall promptly notify the State agency that administers or supervises the administration of the State's plan under title XIX of such Act of the fact of and the reasons for such termination.

(c) The amendment made by subsection (a) shall apply to medical assistance furnished on or after the first day of the first calendar quarter beginning after the date of the enactment of this Act.

O

Mr. WAXMAN. We are pleased to have you with us.

STATEMENT OF HON. TOM BEVILL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. BEVILL. Thank you, Mr. Chairman. I appreciate the opportunity to appear before this distinguished committee.

I have watched this subcommittee with great interest. It turns out some of the best health legislation that we have presented to the Congress, and certainly I commend you, Mr. Chairman, and your subcommittee, for the tremendous job you are doing in improving the health of the people of this Nation. You all do a great job and I certainly want to join my friend and colleague, Richard Shelby, in thanking you for permitting us to have this time here because we do have a very difficult problem in the medicaid field in Alabama, and we appreciate your indulgence.

We have with us here today our top leaders from the State of Alabama in this field. These men are highly respected. And I am also delighted to get to see my good friend, Dr. Carter, who has served with distinction on this subcommittee.

I certainly want to commend my good friend Richard Shelby. Alabama is very proud of the role that he has played on this subcommittee and we appreciate him. I am just here to, frankly, endorse what my colleague, Richard Shelby, says, and to associate myself with the comments of these leaders from Alabama that we have here. These very distinguished gentlemen are playing such a vital role in Alabama in trying to resolve our medicaid problem.

I do appreciate you and the subcommittee permitting us to have this opportunity.

Thank you very much.

Mr. WAXMAN. Thank you.

Dr. Carter? I recognize the distinguished ranking member of the subcommittee, Dr. Tim Carter.

Mr. CARTER. It is a pleasure to join with you, Mr. Chairman, in welcoming Hon. Tom Bevill. I am sorry I didn't get here in time to welcome him as my plane was a little late, but I would like to commend our friends from Alabama, including our distinguished colleague, Mr. Shelby, for bringing this legislation to our attention.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

Without objection, the Chair wishes to place in the record, as though read, the statement of Senator Howell Heflin of Alabama.

STATEMENT OF HON. HOWELL HEFLIN, A U.S. SENATOR FROM THE STATE OF ALABAMA

Mr. HEFLIN. Mr. Chairman, I want to thank you and the other members of the committee for providing me the opportunity to make a brief statement in support of H.R. 7029, HR. 7030, H.R. 7031, H.R. 7028 and H.R. 7486. These bills were introduced by Congressman Richard Shelby and they are cosponsored by the entire Alabama delegation in the House.

As you know, there are strict Federal guidelines covering the medicaid program. This legislation would give the States more flexibility in managing and maintaining this important program

68-669 O—90——2

which provides the health benefits for needy people such as the blind, the disabled, and families with dependent children.

I believe it is important to give the individual States more latitude and decisionmaking options in their efforts to meet the health needs of these citizens.

During the past few months, I have heard from several officials of my State regarding the need to change the Federal law regulating the medicaid program. Some of these Alabama State officials have come here today to offer testimony in support of these bills. It was because of the strong expression of support I received from these Alabama State officials in favor of legislation to eliminate some of the burden of over Federal regulations on the operation of the medicaid program that I introduced this legislation in the Senate.

It is in their behalf and in behalf of medicaid officials in States across the country who share management problems similar to theirs that I appear before you today. And it goes without saying that my involvement is also in behalf of the almost 50 million aged, disabled, and poor Americans who are the beneficaries of the medicaid assistance.

You, the members of the committee may have also heard from officials of your States, expressing similar concerns. Concerns that the Federal Government is over regulating the medicaid program. Over regulating the program to the extent that it ties the hands of State officials to provide a quality service to its recipients.

Indeed, since I introduced these bills in the Senate, I have been contacted by people who reside outside of my State expressing their views in support of this legislation. A doctor in Seattle, Wash., wrote to me recently—he said, "Your introduction of four bills designed to help improve our current medicaid program is of great interest to me. I believe that the changes, which I understand you are proposing, are both very much needed and commendable. In our State," this doctor goes on, "we have been wrestling with our current medicaid program and I can appreciate the importance of some of these proposals."

Mr. Chairman, I join Hon. W. H. (Hope) Kerns, commissioner medical assistance, State of Alabama, Medical Services Administration, Senator Dewey White, Representative Leigh Pegues, and Representative Walter Owens of the Alabama State Legislature in urging you and the members of the committee to examine the applicable Federal statutes relating to the medicaid program as well as the provisions of these bills you are considering today. I hope that you will see fit to favorably report this legislation for action by the full House.

Mr. WAXMAN. Mr. Shelby?

Mr. SHELBY. Thank you, Mr. Chairman. Can I call the panel?

Mr. WAXMAN. I would appreciate it if you would.

Mr. SHELBY. Mr. Hoke Kerns, Dr. Dewey White, Hon. Leigh Pegues, Hon. Walter Owens, if you will come up and have seats here. I would like to say something about every one of these people if I could, if you would indulge.

First of all, Mr. Walter Owens, the gentleman seated there right in front of us in the blue blazer, is chairman of the Ways and Means Committee of the Alabama Legislature, a constituent of

mine, a long-term member of the Alabama Legislature. He is very able. He has been active in State government for many, many years and he is in a position to know some of the real funding problems that we are experiencing in Alabama as far as this program and others.

And on his right is the Hon. Hoke Kerns who is commissioner for the State of Alabama, the Medical Services Administration. He is the one that is having to carry out the program from time to time and on a day-to-day basis and he should and I feel confident will be able to articulate a lot of the problems facing us, and hopefully recommend some solutions through this legislation or through some rules changes.

On Mr. Owens' right, Dr. Dewey White is an Alabama State Senator. He has served one term in the Alabama House. He is chairman of the joint medicaid committee down there and he is also chairman of the health committee in the Alabama Senate and a practicing pediatrician for many years in Birmingham.

On Dr. White's left is Hon. Leigh Pegues who is a member of the Alabama House of Representatives from Marion, Ala. He has been active for many years in the medicaid problem. He was chairman of a select committee that we had there several years ago to study the funding problems of which I was a member and, of course, Mr. Pegues did all the work then.

Gentlemen, on behalf of the committee and on behalf of the chairman and the ranking minority member, Dr. Carter, welcome to the subcommittee here today.

Thank you, Mr. Chairman.

Mr. WAXMAN. I want you to know, Mr. Pegues, that in Washington Mr. Shelby is doing all the work here.

Mr. PEGUES. He is my Congressman.

Mr. WAXMAN. We are pleased to have you gentlemen with us to talk about these bills and to talk about the problem in Alabama. Why don't you proceed in any way you wish.

STATEMENTS OF W. H. KERNS, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, STATE OF ALABAMA; WALTER OWENS, CHAIRMAN, WAYS AND MEANS, ALABAMA HOUSE OF REPRESENTATIVES; DEWEY WHITE, JR., M.D., CHAIRMAN, HEALTH AND WELFARE COMMITTEE, ALABAMA STATE SENATE; AND R. LEIGH PEGUES, ALABAMA HOUSE OF REPRESENTATIVES

Mr. KERNS. Mr. Chairman, we appreciate the opportunity of expressing our views to you on this legislation, and perhaps our views on some other rules and regulations that might benefit the medicaid program both from the Federal viewpoint as well as the State's viewpoint.

I would like for you to know that as commissioner of medicaid in Alabama, I am 100 percent in support of the bills introduced by Congressman Shelby. We are grateful to him for taking the interest in this legislation and introducing these bills.

We support these bills not just because of Alabama but because we believe, I believe as commissioner of medicaid, that these bills will have a very beneficial effect on the medicaid programs in all the States, and I believe, based on my experience and my conversa-

tions with other medicaid directors, that my fellow medicaid directors would almost without exception provide supportive comments if they were given the opportunity to do so.

It is important we realize, I think, that the citizens of Alabama are very concerned about the health care needs of their elderly and their poor, that the State of Alabama seeks to provide that care to the best of their ability, both financially and in terms of management.

We are equally concerned about providing that care in as cost effective and prudent management manner as we possibly can. Escalating costs are hampering us just as they are other States and just as they will the Federal Government. We believe we can provide the care that the Alabama people require in a much more effective and prudent way, and we think that Congressman Shelby's bills will be a substantial step in a proper direction.

Basically, Congressman Shelby's bills enlarge the State's ability to manage in four major areas: One being the copayer or the family share on costs of medicaid benefits; another being some form of family responsibility, even on a voluntary basis for nursing home patients; a third one being the suspension or termination of eligibility for benefits of those who abuse the program, without going through a long, time consuming and expensive litigation process; and the fourth, of course, being the ability to develop contractual agreements between medicaid agencies and providers based on prudent buying practices as we would do in our own business.

On copay, copay requirements for mandated services, particularly physician services are expressly forbidden by Federal law at this time as you know. We think this restriction is unrealistic and should be changed.

The present policy tempts both patients and providers to think of medical care as free and unlimited. In fact, it is expensive and in short supply. When scarce resources such as medical care are used wastefully, then someone has to do without. We think that co-pay would not only save money but it would certainly make available to the rest of the citizenry better health care.

If copay is small enough, it wouldn't prevent patients from receiving the care they really need, but it would help to eliminate much of the misutilization and overutilization of certain services, particularly physicians and hospital emergency room services.

The physicians in Alabama serving medicaid patients are perhaps in the best position to observe this overutilization. Correspondence from Alabama physicians to me overwhelmingly endorsed the concept of some kind of nominal copay arrangement for their services.

When Alabama imposed in 1975 the copayment requirement on drugs, the number of prescriptions dropped by 12 percent. To this date we have received no indication whatever that the copayment requirement on drugs resulted in the denial of essential medication to any recipient, nor do we have any indication that the copayment requirement adversely affected the health or well being of a single Medicaid recipient.

We support Congressman Shelby's proposal to permit nominal copay requirements for certain services, and we will be very

pleased to work with this subcommittee or the Department of Health and Human Services to implement a practical, realistic copayment requirement.

With respect to family responsibility for nursing home patients, earlier this year the Governor of Alabama asked a group of nursing home administrators if in their judgment the sponsors of patients in Alabama nursing homes would contribute voluntarily to the support of these patients. They almost unanimously said yes.

Governor James' question was prompted by his belief that those who can contribute should contribute to the care of their elderly parents, and in some cases, grandparents. We were later advised by the Department of Health and Human Services that a request for voluntary contributions could be construed to be coercive and was therefore contrary to current Federal regulations.

Time does not permit us a lot of dialog on this issue, but the Congress should know that since supplementation—the requirement that relatives of nursing home patients contribute to the cost of their care—was phased out in Alabama in 1974, the number of patients in Alabama nursing homes has increased 30 percent. The cost to taxpayers for caring for these patients has increased 136 percent. Simultaneously, the number of nursing home beds in Alabama has increased 28 percent.

We do not believe that it could have been the intent of Congress in ending supplementation to stifle the State's desire to stimulate voluntary contributions toward the support of the State's nursing home program, particularly the optional intermediate care facility program. Congressman Shelby's proposal would clarify this issue.

Current Federal law allows the State to cancel an individual's eligibility for medicaid only upon conviction of a crime. This requirement is unwieldly, expensive, and impractical. Congressman Shelby's proposal would permit the termination or suspension of benefits of those who abuse the program and would allow such decisions to be made by administrative procedures following an appropriate fair hearing.

I commend this proposal to the Congress as a medicaid commissioner because I believe it will contribute more to the elimination of program abuse by recipients than any other measure yet advocated.

Existing law permits prudent buying practice and prudent contractual arrangements for some medical services and products. Alabama has effectively used the competitive bidding system for eyeglasses. We are advised that other States have been effective in bidding certain other services and products.

Prudent buying practices, however, conflict with Federal law in several instances: The cost-related reimbursement method required for nursing homes; the reasonable cost reimbursement method for hospital services, and the freedom-of-choice provisions for medicaid recipients.

Full Federal payment for incorrectly determined eligibles. Currently, Federal law imposes financial sanctions on States which fail to reduce eligibility errors to acceptable rates within specified periods of time. We have no conflict with this. The law, however, imposes no sanctions on the Social Security Administration for

incorrectly certifying persons for medical assistance through the supplemental security income process.

States which choose to use the SSI mechanism for determining eligibility, which is the most cost effective way, are therefore at the mercy of those who make those determinations. It therefore seems reasonable that the total costs of benefits provided those incorrectly determined to be eligible by social security should be borne by those who make those determinations.

Congressman Shelby's H.R. 7468 provides that the Federal medical assistance percentage will be 100 percent for individuals during those periods in which they have been incorrectly certified as supplemental security income recipients. I respectfully submit that such legislation is reasonable, fair, and should prove to be productive.

I realize that the goals of this subcommittee and of the Congress are essentially the same as those of us in the State of Alabama and I think of the medicaid programs in other States. I, therefore, encourage the subcommittee to favorably consider this remedial legislation because I think it will permit the states to purchase products and services for medicaid recipients, utilizing customary business methods, in a prudent and practical way.

If you have questions, I will be glad to attempt to answer them.

[Mr. Kerns' prepared statement follows:]

STATEMENT OF

W. H. KERNS

COMMISSIONER

MEDICAL SERVICES ADMINISTRATION

STATE OF ALABAMA

Mr. Chairman, Gentlemen of the Subcommittee:

Thank you for this opportunity to come to Washington and talk to this Committee. You are a group who are most influential in shaping Medicaid policy, and as a state Medicaid administrator, I welcome this chance to express my views to you.

I come to speak in support of a group of bills introduced by the Honorable Richard Shelby from Alabama. In supporting them, I speak not only from my own experience, but from what I have been told by Medicaid directors and administrators I have met in the past two years. If you were to poll them you would find, I am sure, strong and widespread support for these bills.

We support these bills because they would enable the states to make decisions in four different areas where, at present, we are constrained. Current federal laws and regulations stifle effective management at the state level, and contribute to Medicaid's chronic budget crises. The legislation introduced by Congressman Shelby would allow the states the discretion they need in these four areas, and would help create the conditions needed for effective management. An additional bill introduced by Congressman Shelby would require the federal government to accept total financial responsibility for their errors.

The citizens and officials of Alabama are very concerned about the health care needs of our elderly and poor. We seek to provide health care for them to the best of the state's ability. And, we are equally concerned with the need to provide that care in a cost-effective and prudent manner. Escalating costs are hampering us, and we need to contain these rising costs. We believe we can do so without curtailing or eliminating benefits. We can, and want to do so, without asking for more federal funds. Alabamians are well aware that federal expenditures are made with funds provided by them as federal taxpayers also.

We seek independence and economy not only for their own sake, but because our resources are scarce. Money, physicians, and other health care resources are in short supply. We cannot afford the inefficiency and waste that result from federal requirements. We seek more independence not to reduce benefits, but to maintain them.

As I said earlier, Congressman Shelby's bills would enlarge the authority of the states in regard to four policy areas. These four are:

1. Co-pay, or family-sharing, on costs of medicaid benefits
2. Family responsibility for nursing home patients
3. Suspension or termination of eligibility for benefits
4. Contractual agreements between Medicaid agencies and providers based on prudent buying practices.

1. CO-PAY

Co-pay requirements for mandated services, particularly physicians' services, are expressly forbidden by federal law. This restriction is unrealistic and should be changed. The present policy tempts both patients and providers to think of medical care as free and unlimited. In fact it is expensive and in short supply. When scarce resources are used wastefully--as they currently are by Medicaid patients--there is not enough to go around; somebody has to do without. Co-pay would not only save money, it would lead to more rational use of scarce resources and would benefit not only Medicaid, but everyone. The 90% of Alabamians who are not on Medicaid would have better access to health care, and the escalation of health care costs would be slowed. And, if the co-pay is kept small enough, it will not prevent patients from receiving the care they truly need. It would eliminate only misutilization and overutilization of certain services, particularly physician and hospital emergency room services.

Physicians serving Medicaid recipients are in the best position to observe overutilization of their services. Correspondence from Alabama physicians overwhelmingly supports the policy of a nominal co-pay requirement. The argument advanced by some groups that co-pay will result in necessary medical services becoming unavailable to the poor cannot be substantiated. Quite the contrary.

When Alabama imposed in 1975 the co-payment requirement on drugs, the number of prescriptions dropped by 12 percent. To this date, we have received

no indication that the co-payment requirement on drugs resulted in the denial of essential medication to any recipient. Nor do we have any indication that the co-pay requirement adversely affected the health or well being of a single Medicaid recipient. We support Congressman Shelby's proposal to permit nominal co-pay requirements for certain services and we will be pleased to work with the Congress or the Department of Health and Human Services to implement a practical, realistic co-pay requirement.

2. FAMILY RESPONSIBILITY FOR NURSING HOME PATIENTS

Earlier this year, the Governor of Alabama, during a breakfast meeting with the leadership of the Alabama Nursing Home Association, asked if in the judgment of the nursing home administrators patient sponsors would contribute voluntarily to the financial support of the nursing home program. Nursing home administrators almost unanimously said, "yes." Governor James' question was prompted by his belief that those who can contribute should contribute to the care of their elderly parents, and in some cases, grandparents.

We were later advised by the Department of Health and Human Services that a request for voluntary contributions could be construed as coercive and therefore contrary to federal regulations. Time does not permit extensive dialogue on this issue. But Congress should know that since supplementation (the requirement that relatives of nursing home patients contribute to the costs of their care) was phased out in Alabama in 1974, the number of patients in Alabama nursing homes has increased 30 percent. The cost to taxpayers for caring for these patients has increased 136 percent. Simultaneously, the number of nursing home beds in Alabama has increased 20 percent.

Certainly, it could not have been the intent of Congress in ending supplementation to stifle a state's desire to stimulate voluntary contributions toward support of the state's nursing home program, particularly the optional intermediate care facility program. Congressman Shelby's proposal would clarify this issue.

3. SUSPENSION OR TERMINATION OF ELIGIBILITY FOR BENEFITS

Current federal law allows a state to cancel an individual's eligibility for Medicaid only upon conviction of a crime. This requirement is unwieldy, expensive and impractical. Congressman Shelby's proposal would permit the termination or suspension of benefits of those who abuse the program, and would allow such decisions to be made by administrative procedures, following an appropriate fair hearing. I commend this proposal to Congress. I believe it will contribute more to the elimination of program abuse by recipients

than any other measure yet advocated.

4. CONTRACTUAL AGREEMENTS BETWEEN A MEDICAID AGENCY AND ITS PROVIDERS

Existing law permits prudent buying practices and prudent contractual arrangements for some medical services and products. Alabama has effectively used competitive bidding for eye glasses. We are advised that other states have been effective in bidding certain other services and products.

Prudent buying practices, however, conflict with federal law in several instances--

the cost-related reimbursement method required for nursing homes,

the reasonable-cost reimbursement method for hospital services,

the freedom-of-choice provisions for Medicaid recipients.

5. FULL FEDERAL PAYMENT FOR INCORRECTLY DETERMINED ELIGIBLES

Currently, federal law imposes financial sanctions on states which fail to reduce eligibility errors to acceptable rates within specified periods of time. The law, however, imposes no sanctions on the Social Security Administration for incorrectly certifying persons for medical assistance through the supplemental security income process.

States which choose to use the SSI mechanism for determining eligibility, which is the most cost effective way, are therefore at the mercy of those who make those determinations. It therefore seems reasonable that the total costs of benefits provided those incorrectly determined to be eligible by Social Security should be borne by the federal government.

Congressman Shelby's HR 7868 provides that the federal medical assistance percentage will be 100 percent for individuals during those periods in which they have been incorrectly certified as supplemental security income recipients. I respectfully submit that such legislation is reasonable, fair, and should prove to be productive.

OTHER UNNECESSARY REGULATIONS

The four federal Medicaid policies I have named are not the only policies that cause waste of money and resources. Alabama has previously supplied the Department of Health and Human Services with a list of unnecessary and costly regulations, and their estimated cost. This material was supplied some seven months ago, and so far we have not been favored with a response or even an acknowledgement that the suggestions were received. The staff of Alabama Medical Services Administration estimated the costs of these regulations to be some $49 million annually--more than a sixth of the total costs of the

Alabama program.

This additional $49 million we were required to spend is particularly onerous in a state where even necessary expenditures are difficult to pay for. Alabama's Title XIX program is, necessarily, austere as compared to programs in other states. In addition to the federally mandated program, Alabama offers only twelve optional programs, placing the state forty-fourth on the list of optional programs offered. Alabama's administrative costs are the second lowest in the nation; only one state, which has an insured program, has a lower percentage of administrative costs as compared with total program costs.

In spite of this austerity, Alabama's Medicaid program this year will total $335 million. This translates into an expenditure of $90 for every man, woman and child in Alabama. During the course of the year, abiding by federal guidelines with respect to eligibility, over 11 percent of the state's population will become eligible for Medicaid. And, about 9 percent of the state's population will use the benefits of Medicaid in one way or another.

Hopefully, this year we will experience a reduction in the admission rate to hospitals. Last year 245 of every 1,000 eligibles became hospital inpatients. Admissions for other people in the state was only 172 per 1,000, and in the nation 169 per 1,000. Surely Medicaid patients are not that much sicker than other people. Our high hospital admission rate suggests waste, and by our own efforts we expect to lower that rate. But for maximum reduction of waste, we need reduction of federal regulations.

I know that our goals and yours are the same. Therefore, I encourage the Congress to pass remedial legislation which will permit the states to purchase both products and services for Medicaid recipients, utilizing customary business methods. We further encourage the Congress to permit the states to limit the present unlimited freedom of choice provisions in such a way that benefits can be provided in cost effective ways without impairing either the quality of services available or access to those services. We encourage the Congress to pass all the bills in this group. It is difficult to select one as more important than the others, though I am tempted to suggest priority for the co-pay bill. All of Congressman Shelby's proposed legislation will contribute toward more efficient management and we hope you will submit them all to Congress with a favorable report.

Mr. WAXMAN. Thank you very much. I appreciate your testimony.

I would like to hear from each of the witnesses. Then we can engage in discussion, questions, and answers.

Mr. Owens?

STATEMENT OF WALTER OWENS

Mr. OWENS. Mr. Chairman and gentlemen of the committee, I consider it a real honor and pleasure to have the opportunity to testify before this subcommittee today. This is the first occasion to appear before a subcommittee during my 14 years of service in the Alabama Legislature, and I want to thank Congressman Shelby for his invitation and I might add, too, I am proud of our Congressman back in our district in Alabama.

I feel that the bills that Congressman Shelby has introduced pertaining to medicaid are desperately needed in order for the State of Alabama to continue adequate funding for the medicaid program.

I am not prepared to address the bills before you specifically, but I do want to explain the fiscal situation as it relates to the medicaid program in Alabama.

The problems that Alabama faces in regard to medicaid are not unique. From various conferences and meetings with legislators from other States it appears to me that many of those States are having similar funding problems. Therefore, I feel that my comments, although specifically related to Alabama, can be indicative of an impending crisis in other States as well.

The State of Alabama began appropriating funds for the medicaid program in 1971. At that time, the total medicaid budget was $85 million with the Federal Government contributing some $67 million and Alabama providing the remaining $18 million. The matching formula required Alabama to contribute approximately 21.5 percent of the budget with Federal dollars accounting for the other 78.5 percent. At that time, Alabama was able to participate in a program that was badly needed and one which she could afford.

However, this does not remain the case today. The total budget for the medical services administration has soared from $85 million in 1971 to an estimated $351 million for 1981. In addition, the State matching percentage required to obtain Federal funds has risen from 21.5 percent to 28.7 percent. Alabama's cost has increased from $18 million to $100 million. Obviously, this compounds the problem that Alabama must deal with in attempting to generate the funds necessary to maintain the medicaid program at an adequate level.

The total appropriation from the general fund of Alabama is approximately $297 million for the fiscal year 1980–81. State funds necessary to continue the medicaid program amount to an estimated $100 million. State appropriations required to fund medicaid has increased from approximately 16 percent of the total general fund budget in fiscal year 1971 to approximately 33 percent in fiscal year 1981.

Alabama could not fund medicaid as well as the other necessary facets of State government this year without additional revenue. In

order to generate this revenue, the legislature enacted several additional taxes, one of which was an additional tax of 4 cents per package on cigarettes which brings Alabama taxes on that product to a total of 16 cents.

But, gentlemen, we cannot continue in this manner. I don't think I need to point out that citizens everywhere are feeling the effects of our present economic problems. Alabamians are no exception. More and more taxes cannot be the answer. Today, one-third of Alabama's general fund appropriation is needed to fund medicaid, and this situation shows no promise of reversal. Something must be done.

A number of ideas and proposals were considered by the Alabama Legislature last session in an attempt to address the medicaid problem. However, we as legislators were repeatedly warned that these proposals were against Federal guidelines and regulations. Thus, the enactment of such proposals would jeopardize Federal participation in the program. In fact, several parts of the cost containment package enacted are currently being litigated in court.

I feel that passage of Congressman Shelby's bills would help to solve some of the legal questions concerning Alabama's cost containment measures. I came here today to explain to this distinguished subcommittee some of Alabama's fiscal problems in the medicaid program and to plead with you for your assistance in addressing these problems.

Mr. Chairman and Mr. Shelby, I consider it a pleasure to appear before this committee and have the opportunity to testify.

Thank you.

Mr. WAXMAN. Thank you very much. I appreciate your testimony.

Dr. White?

STATEMENT OF DEWEY WHITE, JR., M.D.

Dr. WHITE. Mr. Chairman, I want to thank you for the opportunity to come here today and present my few words in support of this legislation.

I think that this is a step in the right direction. I am not sure that these by any means answer the problems that we have. We are talking about the medicaid being the largest single item as far as the State legislatures are concerned in their money appropriations for which they have only a limited control, and this is not just true of Alabama. We happen to all be from Alabama, but this is true of California. This is the largest single item in their State budget. It is out of control.

They have already gone through all of the mechanisms of cost containment. They have gone through all the gyrations that they can as far as eligibility within the Federal guidelines, and each of them—and we have attended national committees and this is true across this country—each of the people that we talked to had a problem with medicaid. They were not able to contain the costs for those people that were close to the problem.

That is the reason we are appearing today, to plead with you to give some relief and some flexibility to the States for the largest item of expenditure in their budget.

We feel that the medicaid program in its origin was probably excellent, but we feel that as we have gone on and have experience in this program, that we are dealing with a situation that has truly proven to be a no-incentive program. In other words, a man that operates a nursing home, the more management he exercises, the more money he collects.

Now how can you ever get ahead and get on top of a situation if you have reverse incentives? This is true of the entire program as you go through it one by one, piece by piece.

We would plead with you to give us some flexibility as far as maybe third level care so that we can cut the cost of taking care of someone that needs supervision because of their age, but they do not need to be in a skilled nursing home or intermediate care facility that is costing them $900 a month. They may be able to be taken care of for $300 or $400 a month. Yet nothing of this type can be handled under the present medicaid program.

We have seen efforts to control as far as cost containment, and they do work, but then we run into Federal regulations, as has been mentioned previously, that hamper us as far as prevention. We also have a problem in this line as far as doing what we can, in that we have some federally funded legal service that is a thorn in our side in carrying out this program, and this is not unique to Alabama either. We have had just recently an example of that.

We passed a piece of legislation that would say that you could get the maximum as far as the Federal regulations went on a drug program, as far as copay. As all of you are familiar, copay is not a mandatory program. This is a voluntary program. Yet the change that would be brought about by our legislation was more than 1 percent, so legally this meant that you had to have a fair hearing and things of this type.

Now how much more than 1 percent? It was 1.07. That was the change that was brought about. By postponing this, going through all the gyrations of a legal hearing such as this as brought on by the Legal Service Corp. suit, then this cost the State in the medicaid program some $60,000 or $70,000. This is the type of thing, gentlemen, that we are looking for.

I presented to you a statement, and I won't go through the bills one by one. I think they have been well presented already. I do support them. I have some reservation about the one on competitive bidding because I feel that this may be the place where we would open up additional bureaucracies, where we would have the State competing in the storage and maintaining of drug supplies and things of this type. I have some caution or reservation about that bill.

Thank you very much, gentlemen. I appreciate the opportunity to be here.

[Dr. White's prepared statement follows:]

SENATE CHAMBER
MONTGOMERY, ALABAMA 36130
832-3543

ALABAMA

DR. DEWEY WHITE, JR.
STATE SENATOR 11TH DISTRICT
P. O. BOX 7089-A
BIRMINGHAM
35233

COMMITTEES:
CHAIRMAN, HEALTH AND WELFARE
JUDICIARY
EDUCATION
COMMERCE, TRANSPORTATION AND UTILITIES
LOCAL LEGISLATION NO. 2

August 8, 1980

Honorable Henry A. Waxman, Chairman
Subcommittee on Health and Environment of
Interstate and Foreign Commerce Committee
2415 Rayburn Office Building
Washington, D. C. 25015

Dear Mr. Waxman:

In accordance with your request, following in brief are the comments on which I will be speaking before your committee at the hearing August 27, 1980:

HR 7028 - We think many people are able to and want to make a contribution to the care of their parents to the extent which they can. I further feel that states should require those that are able to contribute make these contributions in part. This would be a relief to tax payers and also a benefit to those feeling that they had done their best for their families.

HR 7029 - I feel that this is a method of preventing some unnecessary utilization as well as allowing, again, those that can pay some nominal fee do so and not feel that they are accepting something free from the government - this for their own self respect and for the good of the majority of the people. I am very much in favor of this.

HR 7030 - I feel that the same method of the public fair hearing process for providers should apply to consumers, and would be much more expeident in eliminating the lengthy wait necessary for courts to actually have a conviction before termination. This would also strengthen the possibility of preventing people working part time and remaining on Medicaid.

HR 7031 - I have reservations about this bill because much competitive bidding, set up as something to increase

bureaucracy and duplicate the distribution system already being handled by the private sector, would be more of a detriment than an asset. In Alabama we are already using this system to provide eyeglasses, etc.

HR 7468 - If Federal guidelines make the determination of eligibility and these determinations prove to be in error, then Federal monies should be responsible 100% for repayment.

In closing, I feel that some relief will be given by these bills to allow some flexibility at the state level as well as providing some pay by those relatives and involved individuals in the program, and this should be very beneficial in cost containment.

Sincerely yours,

Dewey White, Jr., MD
Senator
11th District

DW/ms

Encl: 28 copies

Mr. WAXMAN. Thank you very much.
Mr. Pegues?

STATEMENT OF R. LEIGH PEGUES

Mr. PEGUES. Thank you, Mr. Chairman and gentlemen of the committee.

Mr. Shelby, you are also a fine gentleman. I am very proud to say you are my Representative. You have done a good job and you have that reputation in the district.

Gentlemen, some steps have got to be taken to hold down the rapidly rising cost of medicaid. We are from Alabama, but I have worked on interim committees for medicaid for some 4 or 5 years. In fact, the first one, now U.S. Senator Donald Stewart was the chairman, and so this is somewhat old hat for me.

I have been to regional meetings and I have been to national meetings of legislators, and unless they are on some specific matter, they always get around to most of the time being consumed on the cost of medicaid. So this is a problem that is not unique to Alabama.

The one problem that Alabama has and maybe some others, in the early seventies it was underfunded but other than that our problems I think are the same. These bills that are before your committee I certainly back 100 percent. They are, though, mere steps in solving the problem of rapidly rising cost in medicaid, and I would like to just give you an overview of what I see as some of the major problems.

The first one is in eligibility. A State is locked in. They have to take too many that are automatically eligible in order to participate in the program which just points out the fact that we have no leeway in choosing our own. We could determine our own eligibility, but it becomes a very complicated and costly factor. Most people that I represent think medicaid is for the elderly. They are shocked to learn that of the 330,000 utilizers in Alabama, 180,000 are not elderly and they are not blind and they are not what they think are disabled.

Unless we can do something about the large eligibility roles, I think we are going to have to cut programs or we are going to have to receive some type of funds from families or from sponsors, but eligibility is a tremendous problem. We have many that are on the eligiblity roles that should not be eligible. We have tried to take steps. We have taken the State payroll and bounced it off the eligiblity list.

We are very much interested in taking other large payrolls if we can get court action in bouncing them off the eligiblity list to cut it down and take off the freeloaders.

The second overriding problem in medicaid is there are no incentives to cut the cost. Psychologically, philosophically it is all bad. You give the worst service at the highest cost, you get the highest reimbursement. We are now investigating a plan in nursing homes that perhaps there could be some free enterprise in it. They would be paid a certain dollar. They would have to meet rigid standards. If they could bring their costs below that, the profit motive would be the incentive. We would review it every year or every 2 years. And we think we could lower that ceiling.

68-669 O—80—3

The problem in hospitals is in cost reimbursements. You actually have cost plus reimbursement. On the extreme, if Senator White here was a favorite of some hospital board and they had a big oil painting of him done and put in the lobby, that would enter into the cost of medicaid. In Alabama we have one hospital that charges over $400 a day. It is my understanding in California there are probably many that charge over $500 a day, and it is very difficult for the taxpayer to see how they can pay that. And I think contractual services, under one of Mr. Shelby's bills, perhaps it would solve some of that problem.

I realize medical doctors admit people to the hospitals. They cannot just turn themselves in. The University of Alabama Hospital is going to treat people for influenza. At their cost per day it is ridiculous. I think contract services would help out in those cases.

The third thing is we need some family responsibility. He has two bills that address that. One is the copay and mandatory services. We have investigated that, tried it in Alabama, $2 copay for a doctor visit. What is happening in interviewing medical doctors who treat many medicaid patients, in many instances it is a social visit for them. They have the philosophy it is free, why shouldn't I avail myself of that. They meet their friends in the physician's office. They also get personal attention from the physician, which is what most of them need anyway. Certainly we do need family responsibility through copay if we could get nothing else.

Then fraud and overutilization. Here is a bill that addresses that. At the present time on medicaid recipients, you have to take them into court and convict them before they are out of the program. In Alabama, in the case of providers, the intermedicaid committee sought to identify the greatest overutilizers in the provider groups, medical doctors and pharmacists and what have you, and bring them to task.

We took some to court where it was out-and-out fraud, but for utilization we gave them due process through a fair hearing officer and then an appeals board, and we were able to get the worst overutilizers out. That can work in the case of providers and suspend them. After all, if I have a medicaid card and I steal $400, you are not going to take me into court and prove fraud and cost the State $12,000 to $15,000. But if they could go through the system with due process, without charges in court or proving fraud, and suspend them, you would only have to suspend a few as we did in the case of medical doctors or pharmacists. The rest of them so-called come to the foot of the cross.

Most of the other has been gone over, but I would like to plead once more, give the States some flexibility in their programs. Everything that we come up with through study, we are told it can't help.

Can you imagine that on the State level? You have the Federal law. You have it interpreted by HEW—I think they have a different name now in Washington—and then regional in Atlanta. Now that is horrible. Early on we tried to work through regional Atlanta. You get nothing. You get no answers. They have a problem. They have to find out higher up, and higher up doesn't know. You have HEW's regulations, regional regulations, and then each State

has its plan. No one can give you an answer. We need flexibility so we can try things.

Right now we can have pilot programs. We have not been allowed to have them in copay and other things. Perhaps we could have programs and then HEW, whatever the name of it is now, could review them every 2 or 3 years and be sure they were good programs. We need a change in medicaid to cut down costs and we need flexibility in State programs.

Thank you.

[Mr. Pegues' prepared statement follows:]

Honorable Henry A. Waxman, Chairman
Subcommittee on Health and
Environment of the Interstate and
Foreign Commerce Committee

The dollar cost to operate the Medicaid Program is a staggering amount and continues to grow at an ever accelerating pace. The Federal Government should either assume the total cost of Medicaid or allow states to institute some cost containment practices.

The bills sponsored by Mr. Shelby would be a step in the right direction for cost containment. HR 7029 would be a good cost containment measure in holding down over utilization. HR 7029 would be similar to what is done by some health insurance plans.

The overriding problems in Medicaid are:

(1) Too many eligibles

(2) Hospitals paid on cost reimbursement

(3) Fraud and abuse, of both providers and recipients

(4) Emphasis, in nursing home care, should be on less long-term skilled domiciliary care to a day care or home health care program

(5) Family responsibility, meaning co-pay or voluntary contribution, should be allowed

(6) Allow providers to have monetary gain if they cut cost; and

(7) Give states more flexibility in management of their programs.

B. Leigh Pegues
Alabama House of Representatives

Mr. WAXMAN. Thank you very much for your testimony.

It is my understanding that in Alabama the standard of need for an aid for dependent children family of four is $240 a month. This is the amount that the State has determined to be the minimum necessary to meet food, shelter, and clothing needs, exclusive of the medical costs.

It is also my understanding that the actual monthly payment for an AFDC family of four is only about 60 percent of the need standard or $148 a month. If these figures are correct, how can we expect an AFDC family to meet copayment requirements for medically necessary primary care?

Mr. Kerns, could you address that?

Mr. KERNS. I think your question is well taken, Mr. Chairman. I think the issue is whether or not all of them are at that basic level. And, second, I see no reason why a copay requirement couldn't be scaled in some reasonable fashion. I don't think it has to be $2 to every person. It could perhaps be 50 cents in some cases and $2 to others. All we are asking for is the flexibility to possibly implement a program, and it is not our desire to create a hardship on the part of those people who can't meet those requirements. Our desire is to curb the overutilization as best we can. We think some form of copay would do that.

Mr. WAXMAN. So you think some form of copay for a family of four, let's say, on AFDC that gets $148, even a token amount may discourage them from using the system when it is not necessary to have to use the system?

Mr. KERNS. That is our belief and that is what our physicians in Alabama seem to believe, Mr. Chairman.

Mr. PEGUES. Mr. Chairman, may I speak to that?

Mr. WAXMAN. Yes.

Mr. PEGUES. In Alabama we had a crisis in the medicaid system and they were 2 to 3 months behind in payments, so many pharmacists, mom and pop stores, couldn't continue and so they cut out the medicaid program as far as their one store is concerned.

We checked with another pharmacist, with a number of pharmacists. We are talking about complete cut-out, and their business was 90 percent. They only lost 10 percent, and they are paying the whole bill.

I would also like to point out on aid, ADC, there is a multiplicity of other programs that they are eligible for, and so that would not be their total income from welfare-type programs. It would be, I believe, several times higher than that for the family of four. You are only speaking of AFDC, but there is medicaid, free breakfast, free lunch, on and on, and it is many times higher than what you stated.

Mr. WAXMAN. Under H.R. 7030, a State would be authorized to suspend eligibility for medicaid after an administrative hearing.

Mr. Kerns, what kind of hearing would that be? What due process protections would apply for eligibles? Would you also support extending these administrative procedures to providers as well as program eligibles?

Mr. KERNS. The provider is dealt with as perhaps you know, Mr. Chairman, in another way, through the fair hearing process or through the fraud unit, if that is indicated.

Mr. WAXMAN. So we are talking solely about eligibles?

Mr. KERNS. In our suggestion here, we would prefer to identify those who were potentially overutilizing the program and bring them before the utilization review committee, give them a hearing if they feel that they have been judged incorrectly, improperly, or if they have justification for gross overutilization of the program. Then the decision would have to be made by, I assume, the Commissioner of medicaid, if we implemented such a program.

Mr. WAXMAN. What due process guarantees? Do you feel there would be a full administrative hearing? You would have an opportunity to——

Mr. PEGUES. As far as the providers are concerned——

Mr. WAXMAN. I am referring to eligibles.

Mr. PEGUES. I know, but I think you could hold for the eligibles if we were allowed to do it. It would go through his overutilization fraud committee, and then if they determined they were going to suspend him, it would then go before a fair hearing officer and the recipient could have his opportunity there. Then there could be an appeals board. There is a five-member board, of which I happen to be a member, appeal for providers. It certainly could be for recipients. Of course, then they have the courts.

Mr. WAXMAN. So you would design the program similar to the way you have it now?

Mr. PEGUES. Yes, sir.

Mr. WAXMAN. H.R. 7028 would provide the opportunity for the State to develop a fund from contributions from the relatives of people in nursing homes. I would like to know how many of your medicaid nursing home patients have any relatives at all, if you have any statistics? How would you assure that the supplementation program would in fact be voluntary? Is it not possible that people in nursing homes wouldn't be told that this is a voluntary program but in fact be told that their relatives had better contribute if they are going to get a change of bedding? Finally, under a voluntary program, how much money would you expect to raise?

Mr. KERNS. Mr. Chairman, at the time we discussed this with the nursing home administrators it was their suggestion to the governor that approximately 80 percent of their patients had sponsors who could contribute something to the support of the patients in their homes. Now whether or not this was a valid projection I can't say. This was just their estimate.

Licensure requires a certain level of quality in a nursing home, so certainly the availability of clean sheets and so forth would still have to be dealt with through a completely different process. So I don't believe that would be a problem.

With respect to the potential for coercion, I think it would certainly have to be monitored. I think this was the concern of the Department of Health and Human Services in telling us we couldn't implement such a program. Certainly it would have to be monitored, and we are perfectly willing to have that program monitored.

Eligibility is determined without regard to whether or not a person would participate in a voluntary program. Eligibility is a completely different element of the program so I don't believe that

you would see a person denied eligibility or a person denied a high level of care if we implemented such a program.

Mr. WAXMAN. Dr. White?

Dr. WHITE. Mr. Chairman, I think that the situation that exists today as far as nursing homes, that what you are worried about maybe is already going on. Nursing homes are charging in the neighborhood of $200 a month for laundry, for instance, which is something that fits within the guidelines set up at the HHS Federal level. This means that they pay in addition, but it goes to the nursing home. It doesn't go to the system. It doesn't go to what we are talking about, the care of the elderly or the care of anybody. It goes directly to the nursing home and there is no lid on this type of thing. I don't know what the coercion is. I don't know that there is any coercion, but the loophole is there and is utilized by the nursing homes under the present system. It is just called laundry today, and it goes up every few months.

Mr. WAXMAN. Mr. Shelby?

Mr. SHELBY. Thank you, Mr. Chairman.

Does Alabama at the current time have a medicaid management information system, Mr. Kerns?

Mr. KERNS. Yes, we do, and it is fully certified.

Mr. SHELBY. And how long has this been in use?

Mr. KERNS. It was up and certified before I became Commissioner. I believe it has been 2 or 2½ years now.

Mr. SHELBY. What kind of savings have come about because of this, if any?

Mr. KERNS. Through the MMIS system?

Mr. SHELBY. Right.

Mr. KERNS. Whether or not you could project precise cost savings I guess is questionable. Certainly through the MMIS system you possess the ability to monitor the program in a much more closely defined way, and I don't know that you could make a cost projection.

Mr. SHELBY. Does Alabama at the present time have an alternative reimbursement system? Have you applied for one?

Mr. KERNS. Yes. I might explain that we have an alternative reimbursement methodology written for hospitals, and we have had the opportunity of discussing this with some of the officials from HHS, and it is ready now to be submitted and hopefully it will be one which the Department of Health and Human Services can accept. It is closely patterned on some of the elements of an alternative method presented by the State of Mississippi and I believe by the State of Georgia.

With respect to nursing homes, we have just completed an extensive study in an attempt to develop an incentive methodology for reimbursing nursing homes. As Mr. Pegues and Dr. White suggested, the present system lacks any incentive whatsoever. We have involved the nursing home leadership in Alabama in the development of this incentive program. It requires certain policy decisions on our part in the next few months, but we are ready to present that as well for approval.

Mr. SHELBY. Didn't you have a joint interim committee on medicaid?

Mr. KERNS. Yes, we have. Senator White has chaired that committee for the last two sessions.

Mr. SHELBY. Dr. White, did you all determine that the number of eligibles in Alabama had not greatly increased during this period?

Mr. WHITE. That is true. It has increased very little.

Mr. SHELBY. But the utilization of the program in itself had grown by leaps and bounds, had it?

Mr. WHITE. About 20 percent I believe in the last year.

Mr. SHELBY. What has legal services done to you as far as this program is concerned?

Mr. WHITE. Every time you turn around they are there knocking on the door with some kind of suit to interfere, like I pointed out, for just carrying out the things that are actually the intent of the law. I am sure that you gentlemen didn't intend for a suit to be brought for 0.07 percent in the drug program as we just recently had. This is the type of thing that we have had that they have been involved in.

Mr. SHELBY. Just to sum up the bills, without taking up all of your time, which of these bills that we have proposed here at your suggestion would have the most utility if they were ever to become law?

Mr. Kerns, do you have any idea?

Mr. KERNS. I think that copay, Congressman, would be my No. 1 priority. If I had to rank them, I would have difficulty ranking some of the others because I think they are all important, but I would say that the copay or the ability to participate in some way or other in the cost of providing services is the most essential element.

Mr. SHELBY. Who has dealt with, on the panel, the problem of fraudulent recipients of medicaid? I know all of you have dealt with it some. You have that everywhere. To what extent do you have that in Alabama, Mr. Kerns?

Mr. KERNS. Congressman, we are intensifying our efforts in this arena right now. We recently had a case, for example, where a young lady used her mother's medicaid card to receive an abortion in a hospital in Birmingham.

Now for us to deal with that, we have to prove, it is my understanding that we have to prove, that the mother intended to defraud the program and that the daughter intended to defraud the program. We spent a substantial amount of time in investigating this case, and have now sent this case to the district attorney in Jefferson County where the incident occurred.

My suggestion is that we could handle this in a much quicker way, a less expensive way, by dealing with such situations in an administrative manner.

Mr. SHELBY. How much money would be saved if you had a competitive bidding opportunity?

Mr. KERNS. I think we could save substantial dollars. I don't know that I could give you an exact projection. Again, I think we could save substantial dollars in certain areas if we could bid, for example, on laboratory services and certain other support services.

I might add here, if you will permit me, that I am not certain that the bidding of pharmaceuticals, as is being done in some

States, and which I understand some in Alabama are concerned about——

Mr. SHELBY. In what States is it being done now, Mr. Kerns, to your knowledge?

Mr. KERNS. The State of Washington did, I believe, Congressman Shelby. Whether they are still doing that or not I am not sure. I would have to go to Commerce Clearinghouse to get that answer for you.

Mr. SHELBY. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I was checking the rise in costs as they have escalated in your State of Alabama. I believe the total medicaid budget in 1971 was $85 million and you estimate it will be $351 million in 1981, and the State's share of that cost will increase about 7 percent; is that correct?

Mr. OWENS. That is correct. It went from 16 percent in 1971 to 33 percent of our general fund, and that was one of the main points I wanted to make. But you are right, 7 percent, 21.5 percent to 28.7.

Mr. CARTER. Approximately 9 or 10 percent of your people in Alabama are medicaid recipients; is that correct?

Mr. OWENS. That is correct.

Mr. CARTER. What percent of the total hospital population for a year, or total number of those hospitalized for a year are medicaid patients?

Mr. KERNS. I think I can answer your question better by saying that medicaid in Alabama is paying for about 8 percent of the inpatient days in Alabama each year.

Mr. CARTER. I thought I read from one of your statements that it is 172 out of 1,000?

Mr. KERNS. I think the statement, yes sir, the statement was to the effect that medicaid admissions this past year were 245 per 1,000 and the rest of the Alabama population is 172 per 1,000.

Mr. CARTER. 172 per 1,000?

Mr. KERNS. Yes, sir.

Mr. CARTER. Of course, that could be a reason for that since more disease is found in poorer families. They have poorer living conditions, is that correct?

Mr. KERNS. I think that is reasonable, yes sir.

Mr. CARTER. In each county of Alabama, how is medicaid eligibility determined? Of course, when an individual is eligible for SSI we know that the individual is then automatically eligible for medicaid. At least in Kentucky it is that way, and I gather in Alabama, too?

Mr. KERNS. Yes, sir.

Mr. CARTER. How do you determine who is eligible for medicaid in each county?

Mr. KERNS. This is done by our department of pensions and security on ADC and AFDC.

Dr. CARTER. Your department of——

Mr. KERNS. Pensions and security. They administer the welfare programs in Alabama.

Mr. CARTER. This would come under the department of human services, in the State of Kentucky.

These people who make medicaid eligibility determinations are employed by the State of Alabama but paid largely by the Federal Government—up to 75 percent, is that correct? Or 70 percent?

Mr. KERNS. I will have to defer on that.

Dr. WHITE. The eligibles determined by that group represent, yes, approximately 60 something percent, 64 percent.

Mr. CARTER. Then in each county, you have people paid for by the Federal Government who determine which people in the county are eligible for medicaid, is that not correct?

Dr. WHITE. As far as those that are blind, the disabled, the SSI, and the ones that are receiving aid to dependent children programs, those are determined by State employees.

Mr. CARTER. The State employees?

Dr. WHITE. Yes, sir. Under Federal guidelines.

Mr. CARTER. Their salaries are partially paid for by——

Dr. WHITE. That is correct.

Mr. CARTER. However, even though they are employed by the State, 70 or 75 percent of their salaries are paid for by the Federal Government?

Dr. WHITE. That is correct.

Mr. CARTER. All right. Each time one of these employees adds another medicaid patient to his list, he becomes surer of his or her job, is that correct?

Dr. WHITE. That is correct.

Mr. CARTER. Yes, sir.

Do you know where Mount Willing is in Alabama?

Mr. PEGUES. I do.

Mr. CARTER. What county is that in?

Mr. PEGUES. It is in Lowndes.

Mr. CARTER. Lowndes County?

Mr. PEGUES. Yes, sir.

Mr. CARTER. About what is the population of Lowndes County?

Mr. PEGUES. I would judge 12,000, 11,000.

Mr. CARTER. 11,000 or 12,000. That happens to be the home of Adm. Tom Moorer, who is a classmate of mine.

Mr. PEGUES. That is right.

Mr. CARTER. How many people are employed there by the medicaid program in that county of 12,000? It parallels a county in my district, that is the reason for my question. About how many?

Mr. PEGUES. The number of eligibles is 4,200 in that county. I have no idea of the number of employees.

Mr. CARTER. You don't have that?

Mr. KERNS. No.

Mr. OWENS. I don't think that the medicaid employees you are speaking of in that county, you are speaking of pension security department employees?

Mr. CARTER. All of them together, FDC, aid to the blind and disabled, and all of that. How many people in that county of 12,000 are employed to oversee these programs?

Mr. OWENS. I represent the county of about 14,000 which is a little larger than that county and we have probably 30 people in that department totally.

Mr. CARTER. Is that enough?

Mr. OWENS. I think it is enough.

Mr. CARTER. Well, I have observed these programs and I have seen in counties of 12,000 sometimes 40 or 50 people employed in these departments when I think that 10—I have been told that 10 could really do the job. Now, every time a patient is added to one of these lists that person becomes surer of his job, is that correct?

Dr. WHITE. Yes, sir.

Mr. CARTER. Suppose we had a committee in Lowndes County or in your county, of five people from various areas of the county, including the doctor, and perhaps a clergyman and a lawyer, to decide on the eligibility of these people for medicaid, welfare or medicaid, do you think that would be helpful?

Dr. WHITE. I think the rolls would be tremendously reduced.

Mr. CARTER. Yes. Don't get us wrong, I want every person, every man, woman, and child who need this assistance, to have it, every one of them. But I do feel in many cases, that may be abused and for that reason, I have suggested on more than one occasion, that we have such a committee.

Now, of course, in a city like Montgomery or Birmingham you would have to go by the wards and have a group such as I suggested, to decide on the eligibility of these cases.

There is one other question, what about the average stay of our medicaid recipients in the hospital?

Mr. KERNS. This has been substantially reduced in the past 2 years.

Mr. CARTER. It is reduced?

Mr. KERNS. Yes, sir. It is presently——

Mr. CARTER. It is on a par with those who pay their own way?

Mr. KERNS. It is presently 5.3 days.

Mr. CARTER. What is it for people who pay their own way?

Mr. KERNS. This is the medicaid.

Mr. CARTER. Yes.

Mr. KERNS. Length of stay?

Mr. CARTER. Do you know what the average stay is for those who pay?

Mr. KERNS. No, sir, I don't have that information.

Mr. CARTER. Do you have any difficulty in getting these people when they are in the hospital to go home, do they like to stay?

Mr. KERNS. In times past, they did like to stay, sir. I think I would have to say that the PSRO organization has become more effective in the arena in recent months. We have seen a substantial increase in the number of no aids issued by them and we have seen a decrease in the average length of stay.

Mr. CARTER. I noticed that you have reservations, Doctor, and Senator, about H.R. 7031, competitive bidding?

Dr. WHITE. I think in the field of pharmaceuticals, for instance, you would get into an unwieldy proposition in trying to warehouse in and all you would do would be increase some type of bureaucracy, be it State or Federal.

Mr. CARTER. Yes, sir.

Dr. WHITE. To try to take care of this under the guise of having competitive bidding. I don't think that is exactly beneficial when

you are going to increase bureaucracy, whether it is competing bidding or not.

I think that the controls that we have exercise a much more prudent cost containment program than you would under the guise of competitive bidding if the State is going to get in the business of warehousing and dispensing medications.

Mr. CARTER. How has it worked with spectacles? I notice that you do have competitive bidding for that. Has it brought the price down?

Dr. WHITE. Yes, sir, it has worked very well. I think the first year the projections were a savings in excess of $300,000 in that program. It is being bid annually now and the optometrist or ophthalmologist, as the case may be, is paid a standard fee, as you know, for examining the patient and then fitting the glasses, but the glasses are all supplied by one major supplier.

Mr. CARTER. There is one difference, this applies to you particularly, Doctor, and also to me. Years ago, not too many years ago, when I was practicing, I made a decision that I would never turn a patient from my door. I hope that, I am sure that you continue the tradition of not turning people away.

I am afraid that when you ask for a copayment, it may have that effect. Do you agree?

Dr. WHITE. No, sir, because I made a talk to the medical association, for instance, since we are talking about the physician part, and one of the doctors got up and said that he got out voluntarily of the program and that he had today 37 percent of his practice was free. He continued to see these people and the majority, if not all of the physicians share this same feeling. In fact, his remark, to quote him, was "that the only difference was that he didn't have to fill out those damn forms and he didn't have to take any Maalox because he didn't have to fool with the government regulations and he was doing much better and his income was greater than it was when he was fooling with medicaid."

Mr. CARTER. I still have a clinic in Kentucky with my nephew, and I realize the number of forms we have, is large. I don't know how many people we have who are doing nothing but filling them out. I know that it is a problem, but I wouldn't want anything to interfere with the patient getting the care which he or she should have.

What percentage of your doctors refuse medicaid in Alabama?

Dr. WHITE. I don't know what the percentage is. In areas where there is a lot of medicaid recipients——

Mr. CARTER. Yes.

Dr. WHITE. There are adequate physicians to take care of the medicaid recipients. In areas where there are very few because of the fact there is complicated paperwork, there are a number that do not participate at all. For instance, in Birmingham area there are quite a few physicians that do not participate in medicaid.

Mr. CARTER. Thank you very kindly, gentlemen, for a very interesting presentation.

Mr. WAXMAN. Mr. Gramm.

Mr. GRAMM. Thank you, Mr. Chairman.

I would like to say first to the members of the panel, that I have enjoyed listening to you. I would consider it a favor to me, if you go

back to Alabama and tell the people there that people on this committee speak of Dick Shelby in the same terms they spoke of Uncas Underwood and Speaker Bankhead.

I am afraid that I believe that most of Mr. Shelby's ideas in these bills make entirely too much sense to be given serious consideration by the Federal Government. There are two people engaged in every medicare transaction but unfortunately, only one person gets any degree of representation from Health and Human Services, and to a large extent, from the Congress, and that is the guy who is on the receiving end. The forgotten person of this decade in this drive to give people things, is the guy who is paying for it.

It seems to me that the strength of the Shelby proposal is that it tries to take some account of the fact that somebody is at the end of the line shelling out hard earned money to pay for all this care and that we ought to try to get some degree of assurances that people really need it and since physicians—I am not a physician as Mr. Carter is—but since physicians are in a very poor position to tell people, don't come back here, that to some extent the burden has to be placed on the guy who is making the decision to show up at the doctor's office, and I think this coinsurance payment is a very good idea. I think it can be scaled, as you had discussions in response to the chairman's question, but I think even if we offset the coinsurance payment by raising basic welfare payments, that we would be better off and people would be better off.

I had to laugh everytime I talked to AMA—I used to be an economist by trade, and in 1964 I sent the Journal of the American Medical Association an article entitled "Disease as a Consumer Good" in which I discussed that as we went more and more toward a system where somebody else pays somebody else's bills and since there is an element in almost all forms of health care that is consumption, whether it is a free meal at a hospital, or getting attention from very highly paid respected members of the community, that this was going to become an element in the demand for medical care.

The AMA sent my article back saying it was a ridiculous article and that the individual who was editing it who had practiced medicine for 25 years, had never known anybody to benefit from a disease. The world has changed a lot since then, AMA has apologized to me for that article on several occasions.

Mr. DANNEMEYER. Did they print it?

Mr. GRAMM. No; today it is so obvious as to not be novel, but unfortunately, the greatest error arises from overlooking the most obvious truths, and these obvious truths are still not recognized by people down in Health and Human Services.

I don't have any questions because I agree with every single word you have said. I do want to have one final question, but I would just simply like to say that I appreciate Mr. Shelby bringing forward these ideas. I appreciate you taking time to come up here and speaking on behalf of them. We have got to do something to try to limit demand for medical care because, as I see it, as a basic element there is almost no limit to what people will take if you give it to them free, and it is very difficult to determine to what point people no longer need medical care, and it seems to me that

setting a coinsurance payment, which is reasonable given a relative income and letting people decide is a fairly good way to go about it.

Since I have heard controversy at least only about one element of the program, and that is competing bid on drugs, I would like to end by just asking one question, and that is, How do you plan to implement this competitive bidding, how do you see it working, what kind of problems do you see with it?

Mr. KERNS. With respect to drugs, Mr. Gramm, I don't believe my recommendation would be that we implement competitive bidding on drugs in Alabama and the reason I say that is because I think the cost of inventorying, whether a State does it or a participating pharmacist does it, becomes too expensive, the cost of perpetual inventories and control and all these things attendant to it would make it an impractical program.

I do believe you can bid laboratory services to the larger laboratories and reduce the costs of providing certain standard laboratory services to patients. We are effectively using it with eyeglasses.

Mr. GRAMM. How would you do it, Commissioner Kerns? Would you do it by letting out a competitive bid and then they would be certified and they would provide the services at a certain price? How would it work in terms of mechanics?

Mr. KERNS. You would bid it just the same as you would any other product or service. You would describe the service to be delivered and you would allow those who are eligible bidders to bid and those who are the lowest responsible, that person or that organization who is the lowest responsible bidder, would receive a contract to provide that for a period of time. Then others would not be disenfranchized, you would not reimburse them at a rate higher than that that you have agreed to contract for.

On laboratory services, if you bid out urinalysis—this is a hypothetical example—you bid urinalysis and get a bid for $2 on the uranalysis, you say to the physician in his office, we will reimburse you for your analysis in the office but we will not pay a price greater than $2 for it.

Mr. GRAMM. It sounds logical to me. Thank you, Mr. Chairman.

Mr. DANNEMEYER. What is the threshold income in Alabama for eligibility for medicaid?

Mr. KERNS. On nursing homes, sir, or ADC and AFDC?

Mr. DANNEMEYER. Both.

Mr. KERNS. For nursing homes it is $481 a month.

Mr. DANNEMEYER. The recipients may not have income in excess of that?

Mr. KERNS. Yes, sir.

Mr. DANNEMEYER. And the AFDC?

Mr. KERNS. I can't respond to that right now, I am sorry.

Mr. DANNEMEYER. Well, let me tell you a little bit how this subcommittee and this committee works on measures of this type. The distinguished colleague from Alabama, your Congressman, has introduced five bills. We all know the numbers of them. In the nature of things, part of the staff work that members receive when they come to this subcommittee for a hearing is an analysis prepared by the administration. In this instance, the administration representatives are here in the room right now.

I don't know whether you are aware of it or not, but they are opposed to four of your five bills. What does that tell us as a practical matter? It tells us these bills, meritorious though they may be, are going nowhere.

Why is that? Politically, you are running up against a philosophy that is inconsistent with what you are trying to do. The leaders of the National Democratic Party are opposed to the philosophy of making changes in this law because they do not trust the States enough to give them the right to administer in the way that you would refer.

Why is that? In their view, States do not properly discharge this responsibility. If you want to change that, obviously from my side of the aisle, you must change the representatives in the Department of Health and Human Services. To do that, you must replace Mrs. Harris; to do that, you must replace Jimmy Carter, who is her boss.

Now you may think that I am ascribing a political necessity to achieve this objective far beyond what it deserves, but let's not kid ourselves, that is precisely what we are talking about.

Like my distinguished friend from Texas, Mr. Gramm, I am one of those who believe that, if taxpayers want a handle on the cost of medicaid in this country we must introduce into the system the duty on the part of the recipient to pay for a portion of the benefits they receive. Because what we have said today is if any medical service known to mankind is to be provided to any citizen on the basis of need by those who make a profit from providing the services, then Katie, I bar the door. There is no limit on the amount of money that can be sucked up to properly care for the health needs of the people of this country.

So how do we get out of it? These bills I think are a modest constructive beginning, but politically they aren't going anywhere until we change the people running the U.S. Congress, and also the White House. I am for you, I will vote tomorrow. I will predict this bill will not come to markup because we won't have time.

Thank you, Mr. Chairman.

Mr. WAXMAN. Dr. Carter.

Mr. CARTER. Yes, Mr. Chairman, as I mentioned to you, my suggestion is that we have a board in each county that determines the eligibility of those who need medicaid, a board of disinterested citizens but intelligent people. I think that would take care of those who really don't deserve it.

The thing that worries me about the copayment is that I remember Willie Brown, who came into my office one time with appendicitis, an abcessed appendix, and I told him, "Willie, you have got appendicitis, you have got to be operated on." He broke down and cried. He was a sharecropper, he said, "Doctor, I don't have any money."

When he said that, I said, "Well, we will make it, we will get it for you anyway, we will get you in." But there are so many people in that condition that the copayment part of this disturbs me.

I think we can manage it in a different way. You know, sometimes regardless of what some of our friends say, there will be a time when we will be called on to answer "I was a stranger and you took me in; I was hungry and you fed me; I was sick and you

gave me succor." To me that is the basis of everything. I just must say that anyone who is poor, who is needy, who doesn't have the money, must be taken care of.

Thank you, Mr. Chairman.

Mr. GRAMM. Would you yield?

Mr. CARTER. I am just happy to yield to my distinguished friend from Texas.

Mr. GRAMM. Lord knows I am not going to pick an argument with the distinguished gentleman from Kentucky, given we are so close to closing our business and he is going to deny us his services in the next Congress by retiring.

I would like to add that given your statements, and I certainly believe that they are true, there are going to be a lot of American taxpayers in heaven from what they have given, and I would just like to add that taking your analogy one step forward, what about the situation where I am driving a truck in Alabama, and I am making $12,000 a year, I am working hard, and I have got children that get sick like everybody else, and price is an element in any decision whether to take them to the doctor.

My wife works, too. She has got to take off work. She has to take them to the doctor so it costs me. Not only do I have to pay the doctor, since I am not covered by medicare-medicaid, but my wife has to lose time at work. She is an hourly employee, it is a sacrifice on my part, I am the guy pulling the wagon, all the rest of these people are riding in the wagon. They don't have to take off work to go to the doctor because they don't work. I am sacrificing.

It is a decision to me, should I—Billy has a cold and it doesn't look like he is going to turn into pneumonia but he has been sick for 2 days, should my wife take off work, should I pay the $15 or whatever and take him to the doctor. That is dollars and cents, a hard economic decision.

Now, should that element, Dr. Carter, not be present on the guy who is not working, who is riding in the wagon I am pulling? I think that is the question that working Americans ask. Their complaint is not the guy who is desperately sick who has a ruptured appendix, who has a blast crisis cancer, their problem is with somebody who falls in a category that is not so acute. Should not they face some economic threshold like the guy who is paying the bill? I think that is the relevant question. I am not sure I have a comfortable answer.

Mr. CARTER. In answer to my friend from Texas who is an economist, we know economists are great people. I understand they all have degrees, rather long gold chains, keys on one end of the chain, no watch on the other end.

Mr. GRAMM. I don't have even have the chains.

Mr. CARTER. I say that is what the definition that Albin Barkley gave me.

Let's go back to what I said before. The truck driver draws $12,000 a year, probably has Blue Cross and Blue Shield, has good insurance. I am speaking of these poor people who don't have any money, who have very little money, and I must say that they must be taken care of. The very poor people, and I am one of those people that he talks about, he talks about how hard it is on the taxpayer and I realize that, I have paid more in income taxes than

I have received in salary every year since I have been here, and if it goes to help those people, so be it.

After all, we are pretty fortunate to be able to pay the Federal Government, that is not any sin.

Mr. SHELBY. Would you yield?

Mr. CARTER. No, sir. Our government cannot exist without our paying our taxes. I would be happy to yield.

Mr. SHELBY. Dr. Carter, I think we all, as members of the committee, share some of your sentiments; that is, that no one should be denied medical care, medical services, because they don't have any money. I mean that is a basic premise, it is mine, and I agree with this. All these bills are, and the gentlemen from Alabama are recommending, have recommended to me and the other members of my delegation, as well as my two Senators, who introduced the bills in the Senate, would be to give some flexibility to the program.

If we start out with a premise that you enunciated, well let's don't turn our back on these people, let's don't turn our back, I agree with that, but let's do give the States, not only the State of Alabama but the other 49 States in the Union, some flexibility in the program and see if it will work.

Mr. CARTER. If I may reclaim my time. I agree with what the gentleman has said and much of what he says in his bill. Where I don't agree is with requiring the patients like Willie Brown, saying that he must have a copayment, when he is faced with death if he doesn't have the few dollars in his pocket. I yield back the balance of my time. Thank you, sir.

Mr. WAXMAN. Let me thank you for your testimony and commend you for bringing this to our attention. As I am sure you have experienced back in the legislature, there are different opinions as to how to really accomplish, I think, the same goal. None of us wants to take away from the poor the opportunity to get needed health care services. Yet we must balance that concern with the need for flexibility at the State level to administer the medicaid program effectively to avoid fraud and waste in the system.

I think the proposals you brought to us are very worthy of our looking at and examining and thinking through as carefully as possible. That is why we held this hearing. That is why your Congressman and your whole delegation has urged us to pass this legislation.

I want to thank you and commend you for the presentation you have made. I think you have the best arguments you can for this kind of flexibility on the State level.

I would like to now call Karen Davis, Deputy Assistant for Planning and Evaluation/Health, Department of Health and Human Services; Paul Willging, Bureau of Program Operations, Health Care Financing Administration.

68-669 O—80——4

STATEMENT OF KAREN DAVIS, PH. D., DEPUTY ASSISTANT FOR PLANNING AND EVALUATION/HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY PAUL WILLGING, PH. D., BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, PUBLIC HEALTH SERVICE

Dr. DAVIS. I have a somewhat longer statement I would be happy to submit for the record but I thought I might just mention some of the highlights. [See p. 52.]

Mr. WAXMAN. Without objection, your complete statement will be made part of the record. We would appreciate a summary of it so we can engage in some questions and answers.

Dr. DAVIS. Mr. Chairman, and members of the subcommittee, thank you for inviting me to be here today. The four amendments which you are considering, H.R. 7028, H.R. 7029, H.R. 7030 and H.R. 7031, are intended to address a critically important issue—the problem of rising costs in the medicaid program.

The escalating costs of medical care are a pressing national problem. I share your concern with the burden increasing medicaid expenditures can impose on both Federal and State budgets. I am also concerned, as I know you are, with the need to fulfill our commitments to the most vulnerable in our society.

Before discussing the amendment under consideration, I would like to review briefly our experience with the medicaid program. Since 1968, medicaid expenditures have grown from combined Federal and State spending of $3.5 billion to about $25.3 billion in 1980. This increase is primarily due to three factors:

First, inflation is driving up the costs of medicaid.

Second, the number of beneficiaries has grown to 21.4 million Americans in 1979. In recent years, however, the number of recipients has barely increased at all.

Third, long-term care costs are consuming a higher proportion of the medicaid budget—from 30 percent in 1968 to 42 percent in 1978.

The impact of health care inflation on medicaid cannot be understated. Adjusted for inflation, payments per recipient have only increased by 33 percent in the last 10 years—less than the increase in real per capita health spending for the population as a whole.

The truth of the matter is that our expenditures for services to the poor and disadvantaged are not out of line with what you and I and others privately spend on medical care. This does not mean we should not be concerned about medicaid costs. We should be worried. The driving force behind today's budget constraints is rising health care costs and we cannot continue to meet even those health needs we now cover unless we can control these rising costs.

With this in mind, I would like to turn to the four amendments which you are considering today. Although these proposals are separate and distinct, they can, I believe, be examined in light of two principal criteria:

One, will they achieve significant cost savings?

Two, will they impost significant harmful effects on medicaid beneficiaries?

With the exception of one proposal which would allow States to use competitive bidding for some medicaid services, we believe that

these amendments would have a highly detrimental impact on medicaid beneficiaries, and in all likelihood would not produce significant cost savings. In fact, in some cases, these amendments can result in increased costs.

First, I would like to discuss H.R. 7029. This proposal would allow States to charge copayments for basic services provided to the categorically needy. H.R. 7029 would make two major changes in the current policy. First, it would allow copayments for basic services such as hospital and physician care. Second, it would permit States to require that these copayments be paid by the poorest in our society—those receiving SSI and AFDC.

The Department strongly opposes this proposal.

We believe that imposition of the proposed copayments could create significant barriers to receipt of necessary medical care by SSI and AFDC recipients, resulting in harmful economic consequences and a deleterious effect on the health of the medicaid population.

There is a considerable body of literature and practical experience on the impact of cost sharing on utilization. The studies generally agree on the following:

Use of ambulatory and preventive services is, indeed, extremely sensitive to copayments. Copayments on ambulatory services significantly reduces utilization, especially among the poor.

One study of privately covered individuals found that a 25-percent copayment on physician services led to a 24-percent reduction in per capita physician visits. A followup study demonstrated that the impact of these copayments was greatest among the lowest income families—who reduced participation in the plan.

It is clear that copayments reduce utilization by the poor. But is it desirable to do so—or will copayments be more likely to deter the poor from seeking necessary and appropriate medical services?

There is little evidence at present that the poor in general overutilize health care services. The poor in every age group are somewhat less likely to have seen a physician during the past year than the nonpoor. Medicaid beneficiaries specifically show little evidence of overutilization. Recently available data from the Rand national health insurance experiment suggest that the poor with medicaid make about the same number of visits to physicians on average as the more well to do.

More importantly, it appears low income Americans may actually receive fewer health services than they require. The poor continue to be less healthy than the nonpoor. If health services were used according to need, then the poor would use more services than the nonpoor. In fact, the poor receive fewer services than more affluent people of comparable health status.

For persons who identify themselves as being in fair or poor health, the more affluent make about twice as many physician visits as the poor.

Differences in utilization are particularly evident among children. Young children in high income families are 25-percent more likely to see a physician during a year than poorer children—yet we know that care received in the early years forms the basis of a child's health throughout life.

The poor already underutilize necessary preventive care. For example, women in low income families are 50-percent less likely to have early prenatal care then more affluent women. Poor women are 40-percent less likely to have had a Pap smear. These are the kinds of services most likely to be reduced by copayments—although we know that preventive care and early prenatal care are key determinants of the health of both mother and child.

With this general picture in mind, let me now turn to medicaid beneficiaries. There are four major concerns which lead us to conclude that imposition of copayments on this population can be particularly harmful.

First, medicaid beneficiaries already face many barriers to access to care—and copayments would add one more to this lengthy list.

Second, copayments on hospital care are especially burdensome and could have long-term effects on individual health.

Third, copayments could impose significant financial hardships on the poorest in our society who are less able to afford a particular dollar level copayment than other groups.

Fourth, as a method of cost containment copayments may be counterproductive and lead to increased program cost.

Let me disuss each of these briefly:

First, medicaid beneficiaries already experience considerable barriers to access to care. Thirty-six States impose limits on the amount, duration and scope of services or require preauthorization of covered basic services under medicaid.

Many physicians do not participate in medicaid—either because of low payment rates or because they do not care to serve this needy population. Over one-half of medicaid patients are seen by less than one-fifth of the physicians in the country. In California, only one out of five obstetrician-gynecologists see medicaid patients.

Second, copayments on hospital services can impose barriers which are particularly devastating. If a medicaid recipient were required to pay even one-half the cost of the first day of care, the economic impact on that family would be overwhelming. For example, in 1979, an AFDC family of four in Alabama received only $148 a month from that program. A family would have to spend fully half of that monthly payment to cover a hospital copayment equal to one-half of the cost of a day in the hospital.

This leads to my third concern. For the medicaid population, copayments, however small, represent a considerable financial hardship. Let us remember that we are talking about copayments to be paid by AFDC and SSI recipients—the poorest of the poor who would have to pay the charges out of their meager welfare checks. Many States have not increased the welfare payment level or eligibility level since inflation began to rise rapidly in the late seventies.

In 1979, the average State welfare payment level was $360 per month—and half the States paid less. This is about 55 percent of the Federal poverty level for a family of four. In five States, Alabama, Mississippi, South Carolina, Tennessee, and Texas, welfare payment levels are below $150 a month or under $35 a week. For families in this income level, the tradeoff for expenditure of each dollar of income is enormous; $1 or $2 spent for medical care

must come out of the less than $35 available to feed, clothe, and care for all four members of the family in a week.

Finally, as methods of cost containment, imposition copayments on services for medicaid beneficiaries appears counterproductive. HHS estimates that this proposal would cost the Federal Government $27 million, and increase State medicaid costs by $22 million. These increased costs occur because reduced use of ambulatory care by medicaid beneficiaries appears to lead to higher utilization of hospital services.

In conclusion, copayments are regarded as a method of reducing utilization of health services. This they can do, but we believe copayments are inappropriate for basic services for AFDC and SSI medicaid beneficiaries. The cost to medicaid beneficiaries in lack of necessary health services and reduced health status could be far too high for any conceivable benefit.

Now, let me turn to the other three amendments.

H.R. 7031. This amendment permits States to arrange for the purchase of laboratory and X-ray services, family planning supplies, prescription drugs, dentures, prosthetic devices or eye glasses through competitive bidding or other means as long as adequate services will be available from qualified providers of care.

The administration supports bulk purchase of supplies which are likely to produce a cost savings without unreasonable inconvenience, delay or expense to beneficiaries. We have submitted a proposal similar to H.R. 7031 in our 1981 medicare and medicaid amendments, but without some of the problems of H.R. 7031.

We prefer the administration's approach because its application to both medicare and medicaid would coordinate competitive bidding under both titles XVII and XIX.

The administration's proposal assures protection to beneficiaries. It applies to those services which beneficiaries ordinarily do not choose, like laboratory tests, and medical devices which usually do not vary in quality among suppliers.

Some items included in H.R. 7031 are inappropriate for the restrictions on freedom of choice inherent in bulk purchasing. Family planning supplies, for example, are obviously in this category. X-ray services can sometimes be provided most appropriately in the office of the physician freely chosen by beneficiaries.

Let me note here that there is an important distinction between these proposals for competitive bidding for bulk purchases of supplies and other proposals to restrict freedom of choice of health providers. Competitive bidding for supplies or procedures which are not chosen by the beneficiary, like laboratory tests or medical devices, does not directly affect patient access to care. Permitting States to limit medicaid beneficiaries' access to specific health care providers, such as hospitals or health centers, however, would directly limit patient access to care.

We believe that patients should have freedom of choice of services whose accessibility depends upon direct contact between patient and provider and general availability to the patient. As I pointed out previously, medicaid beneficiaries already experience difficulties obtaining access to care. These would be exacerbated by any proposal allowing States to restrict access to providers.

Another critical concern is that such restrictions effectively denies patients free choice of physician. The physician a medicaid recipient chooses for ambulatory care may not have admitting privileges at the approved hospital. Thus, a medicaid beneficiary may receive prenatal care from a physician of her choice, but can find that this physician cannot perform the delivery.

Finally, we must remember that the lowest cost institution does not necessarily provide services of similar quality to the higher cost one. For example, some hospitals may appear to have lower costs because they have aging plants or fewer nurses or underpaid staff.

H.R. 7028 would provide that nothing in title XIX of the Social Security Act would be construed to prohibit a State from establishing a program under which relatives of medicaid patients in nursing homes could contribute voluntarily to a fund for payment for their care under the State medicaid plan. We oppose the proposal.

There is considerable potential for abuse in any proposal which allows States to solicit voluntary payment from families of medicaid beneficiaries residing in nursing homes. It would be difficult to control against undue pressure and arm twisting for voluntary contributions, and difficult to prevent discrimination against beneficiaries who cannot produce such contributions.

In order to prevent such abuses, the Department's regulations do not permit medicaid providers to accept payment from any source to supplement payment under the State medicaid plan for the costs of care and services covered by medicaid.

H.R. 7030. This proposal would facilitate termination of eligiblity for medical assistance for individuals determined to have abused the medicaid program. Currently such individual's eligibility can be terminated upon conviction of criminal fraud or conversion with regards to medicaid benefits. The amendment would permit such a suspension of benefits based merely on an administrative hearing rather than a criminal conviction.

First of all, you must realize that, to the extent that there can be significant savings through fraud and abuse control, it will come from providers rather than beneificiaries. We have considerable authority to address this problem in section 1909(a) and the Fraud and Abuse Amendments of 1977—Public Law 95-142. The Department is directing a substantial effort toward the problem of provider abuse.

Nonetheless, fraud and abuse by medicaid recipients does happen and there is clear authority to address these circumstances.

We are currently engaged in intensive efforts on medicaid quality control—aimed to reducing error rates in medicaid eligibility and payments.

In the case of eligibility fraud, individuals who lie about their income can be immediately dropped from the program if they do not meet eligibility criteria.

In cases of chronic abuse or overutilization of services a State may seek a lock-in arrangement—formal procedures under which individuals identified as chronic abusers select one primary care provider and/or pharmacists. This approach has been used successfully in several States.

Not only is H.R. 7030 not necessary and not likely to produce significant savings; it could have a harmful impact particularly if a

State wanted to use this mechanism to substantially reduce its medicaid rolls. As administrative practices vary considerably, this provision would not adequately assure due process for the beneficiary.

In conclusion, the administration opposes all the amendments you are considering today. The potential harm far outweighs any cost savings they might yield.

Thank you for the opportunity to appear before you. If you have any questions, I will be happy to answer them.

[Testimony resumes on p. 71.]

[Dr. Davis' prepared statement follows:]

Statement by

Dr. Karen Davis

Deputy Assistant Secretary

for Planning and Evaluation/Health

Department of Health and Human Services

Mr. Chairman and members of the Subcommittee, thank you for inviting me to be here today. The four amendments which you are considering (H.R. 7028, 7029, 7030 and 7031) are intended to address a critically important issue -- the problem of rising costs in the Medicaid program.

The escalating costs of medical care are a pressing national problem. I share your concern with the burden increasing Medicaid expenditures can impose on both Federal and State budgets. I am also concerned, as I know you are, with the need to fulfill our commitments to the most vulnerable in our society. The Medicaid program is the mainstay of health care financing for the poor. The program serves 21.4 million people, at a combined federal and State cost of about $25 billion in FY 1980. As we seek to contain health care costs, we must be constantly aware of the potential impact of our actions on those who rely upon Federal programs for assistance -- the poor and disadvantaged.

Before discussing the amendments under consideration, I would like to review briefly our experience with the Medicaid program. These amendments are intended to reduce Medicaid expenditures. To comment upon them adequately and appropriately, it is important to understand the dynamics underlying cost increases in Medicaid.

Since 1968, Medicaid expenditures have grown from combined Federal and State spending of $3.5 billion to about $25.3 billion in 1980. This increase is primarily due to three factors:

- First, inflation is driving up the costs of Medicaid. The medical care price index has increased at an average annual rate of 7.6% over the last 10 years. Institutional services, which account for 73% of the Medicaid dollar, experienced even more rapid inflation.

- Second, the number of beneficiaries has grown. In 1979 more than 21.4 million Americans received benefits, an 86% increase in beneficiaries since 1968. In recent years, however, the number of recipients has barely increased at all -- only 1% between 1975 and 1979. This is partly due to the fact that eligibility has become more restricted since income eligibility levels for cash assistance programs have, for the most part, not been raised with inflation.

- Long-term care costs are consuming a higher proportion of the Medicaid budget -- from 30% in 1968 to 42% in 1978. The aged accounted for only 16.2% of the recipients in 1976 but used 38% of total Medicaid dollars -- and 71% of the expenditures for long term care.

The impact of health care inflation on Medicaid cannot be understated. If we look only at changes in annual Medicaid payments per recipient, it appears that Medicaid expenditures per capita almost tripled between 1968 and 1978. However, adjusted for inflation, payments per recipient have only increased by 33% in those ten years. This is actually less than the increase in real per capita health spending for the population as a whole -- 43% between 1968 and 1978.

The truth of the matter is that Medicaid spends no more on health care than is spent for the average American citizen. Our expenditures for services to the poor and disadvantaged are not out of line with what you and I and others privately spend on medical care.

This does not mean we should not be concerned about Medicaid costs. We should be worried:

... Because today's dollars will buy less medical care tomorrow,

... Because more than half of the poor are still not covered by Medicaid , and

... Because there is enormous demand on limited Federal, State and local dollars for both health and other human service programs.

The driving force behind today's budget constraints is rising health care costs and we cannot continue to meet even those health needs we now cover unless we can control these rising costs.

With this in mind, I would like to turn to the four amendments which you are considering today. Although these proposals are separate and distinct, they can, I believe, be examined in light of two principal criteria:

- Will they achieve significant cost savings?

- Will they impose significant harmful effects on Medicaid beneficiaries?

With the exception of one proposal which would allow States to use competitive bidding for some Medicaid services, we believe that these amendments would have a highly detrimental impact on Medicaid beneficiaries, and in all likelihood would not produce significant cost savings. In fact, in some cases, these amendments can result in increased costs.

H.R. 7029

First, I would like to discuss H.R. 7029. This proposal would allow States to charge copayments for basic services provided to the categorically needy. At present, copayments may only be charged for optional services provided to the cateogorically needy and for all services provided to the medically needy. Prescription drugs are the principal service for which copayments are required by States; 14 States impose such charges.

H.R. 7029 would make two major changes in the current policy. First, it would allow copayments for basic services such as hospital and physician care. Second, it would permit States to require that these copayments be paid by the poorest in our society -- those receiving SSI and AFDC.

The Department strongly opposes this proposal.

We believe that imposition of the proposed copayments could create significant barriers to receipt of necessary medical care by SSI and AFDC recipients, resulting in harmful economic consequences and a deleterious effect on the health of the Medicaid population.

The rationale for using copayments (or other methods of cost-sharing) to contain costs is fairly simple. If care is free, people will seek more services. If, on the other hand, there is a personal direct cost for medical care, consumers will be more careful and will not use too many services. The logic behind this approach may well be appropriate for the high income population. For low income populations, it raises a number of fundamental problems.

There is a considerable body of literature and practical experience on the impact of cost-sharing on utilization. The studies generally agree on the following:

- Use of ambulatory and preventive services is, indeed, extremely sensitive to copayments. Copayments on ambulatory services significantly reduces utilization, especially among the poor.

- One study of privately covered individuals found that a 25% copayment on physician services led to a 24% reduction in per capita physician visits. A follow-up study demonstrated that the impact of these copayments was greatest among the lowest income families -- who reduced participation in the plan.

- In Saskatchawan, imposition of small copayments for outpatient care (about $2 per visit) resulted in a 7% reduction in use of medical services by the general population, but a 18% reduction in services to the poor.

It is clear that copayments reduce utilization by the poor. But is it desirable to do so -- or will copayments be more likely to deter the poor from seeking necessary and appropriate medical services?

There is little evidence at present that the poor in general overutilize health care services. The poor in every age group are somewhat less likely to have seen a physician during the past year than the nonpoor. Medicaid beneficiaries specifically show little evidence of overutilization. Recently available data from the Rand National Health Insurance Experiment suggest that the poor with Medicaid make about the same number of visits to physicians on average as the more well-to-do.

More importantly, it appears low income Americans may actually receive fewer health services than they require. The poor continue to be less healthy than the nonpoor. If health services were used according to need, then the poor would use more services than the nonpoor. In fact, the poor receive fewer services than more affluent people of comparable health status.

- For persons who identify themselves as being in fair or poor health, the more affluent make about twice as many physician visits as the poor.

- Differences in utilization are particularly evident among children. Young children in high income families are 25% more likely to see a physician during a year than poorer children -- yet we know that care received in the early years forms the basis of a child's health throughout life.

- The poor already underutilize necessary preventive care. For example, women in low income families are 50% less likely to have early prenatal care than more affluent women. Poor women are 40% less likely to have had a Pap smear. These are the kinds of services most likely to be reduced by co-payments -- although we know that preventive care and early prenatal care is a key determinant of the health of both mother and child.

With this general picture in mind, let me now turn to Medicaid beneficiaries. There are four major concerns which lead us to conclude that imposition of copayments on this population can be particularly harmful.

- First, Medicaid beneficiaries already face many barriers to access to care -- and copayments would add one more to this lengthy list;

- Second, copayments on hospital care are especially burdensome and could have long-term effects on individual health.
- Third, copayments could impose significant financial hardships on the poorest in our society who are less able to afford a particular dollar level copayment than other groups.
- Fourth, as a method of cost containment copayments may be counter productive and lead to increased program cost.

Let me discuss each of these briefly:

First, Medicaid beneficiaries already experience considerable barriers to access to care. Thirty-six States impose limits on amount, duration and scope of services or require preauthorization of covered basic services under Medicaid. Many physicians do not participate in Medicaid -- either because of low payment rates or because they do not care to serve this needy population. Over one-half of Medicaid patients are seen by less than one-fifth of the physicians

in the country. In California, only one out of five obstetrician-gynecologists sees Medicaid patients. Second, copayments on hospital services can impose barriers which are particularly devastating. If a Medicaid recipient were required to pay even one half the cost of the first day of care, the economic impact on that family would be overwhelming. For example, in 1979 an AFDC family of four in Alabama received only $148 per month from that program. A family would have to spend fully half of that monthly payment to cover a hospital copayment equal to one-half of the cost of a day of hospital care.

I know of one case occuring in a State which, for a short period of time, had a Medicaid copayment requirement for cash assistance recipients under an experimental waiver. A young Medicaid recipient with a football injury was taken from hospital to hospital -- only to find that the nearby hospitals would not admit him without the required $25 copayment. Not surprisingly, this welfare family could not pay the deposit, given that the average monthly welfare payment in that State for a family of three was $76, and he was eventually taken to the county hospital, miles away. Today, this young man is permanently paralyzed - and it seems that had he been treated initially, he would be walking today.

This leads to my third concern. For the Medicaid population, copayments, however small, represent a considerable financial hardship. Let us remember that we are talking about copayments to be paid by AFDC and SSI recipients -- the poorest of the poor who would have to pay these charges out of their meager welfare checks. Many States have not increased the welfare payment level or eligibility level since inflation began to rise rapidly in the late 70s.

In 1979, the average State welfare payment level was $360 per month -- and half the States paid less. This is about 55% of the Federal poverty level for a family of four. In 5 States -- Alabama, Mississippi, South Carolina, Tennessee and Texas -- welfare payment levels are below $150 per month -- or under $35 a week. For families at this income level, the tradeoff for expenditure of each dollar of income is enormous. $1 or $2 spent for medical care must come out of the less than $35 available to feed, clothe and care for all four members of the family in a week.

Finally, as a methods of cost containment imposition of copayments on services for Medicaid beneficiaries appears counter-productive. HHS estimates that this proposal would cost the Federal government $27 million - and increase State Medicaid costs by $22 million. These increased costs occur because reduced use of ambulatory care by Medicaid

beneficiaries appears to lead to higher utilization of hospital services.

One example occurred during California's Medi-Cal copayment experiment. The State charged $1 per visit for the first two physician visits. Analyses of the California experience indicated that, while ambulatory visits went down by 8%, hospital utilization increased by 17%. Overall, total program costs seemed to have increased as well.

In conclusion, copayments are regarded as a method of reducing utilization of health services. This they can do, but we believe copayments are inappropriate for basic services for AFDC and SSI Medicaid beneficiaries. The cost to Medicaid beneficiaries in lack of necessary health services and reduced health status could be far too high for any conceivable benefit.

Now, let me turn to the other three amendments.

H.R. 7031

This amendment permits States to arrange for the purchase of laboratory and x-ray services, family planning supplies, prescription drugs, dentures, prosthetic devices or eye glasses through competitive bidding or other means as long

as adequate services will be available from qualified providers of care.

The Administration supports bulk purchase of supplies which are likely to produce a cost savings without unreasonable inconvenience, delay or expense to beneficiaries. We have submitted a proposal similar to H.R. 7031 in our 1981 Medicare and Medicaid amendments, but without some of the problems of H.R. 7031. The Administration's bill would allow States to make bulk purchase agreements for supplying laboratory services, durable medical equipment, hearing aids, eyeglasses and prescription drugs. Our proposal is expected to save Medicaid $3 million.

Our proposal would require that the items and services are reasonably accessible and of acceptable quality. The proposal would also authorize bulk purchasing under Medicare, with waiver of both the coinsurance and the deductible for diagnostic lab tests reimbursed on a negotiated rate basis. It would also expand the negotiated rate authority to include items of durable medical equipment.

We prefer the Administration's approach because:

- Its application to both Medicare and Medicaid would coordinate competitive bidding under both Titles XVIII and XIX.

- The Administration's proposal assures protection to beneficiaries. It applies to those services which beneficiaries ordinarily do not choose, like laboratory tests, and medical devices which usually do not vary in quality among suppliers.

- Some items included in H.R. 7031 are inappropriate for the restrictions on freedom of choice inherent in bulk purchasing; family planning supplies, for example, are obviously in this category; x-ray services can sometimes be provided most appropriately in the office of the physician freely chosen by beneficiaries.

Let me note here that there is an important distinction between these proposals for competitive bidding for bulk purchases of supplies and other proposals to restrict freedom of choice, to health care providers. Competitive bidding for supplies or procedures which are not chosen by the beneficiary, like laboratory tests or medical devices, does not directly affect patient access to care. Permitting States to limit Medicaid beneficiaries access to specific health care providers, such as hospitals or health centers, however, would directly limit patient access to care.

We believe that patient's should have freedom of choice of services whose accessibility depends

upon direct contact between patient and provider, and general availability to the patient. As I pointed out previously, Medicaid beneficiaries already experience difficulties obtaining access to care. These would be exacerbated by any proposal allowing States to restrict access to providers.

- Another critical concern is that restricting choice of hospitals can reduce quality. For one thing, such restrictions effectively denies patients free choice of physician. The physician a Medicaid recipient chooses for ambulatory care may not have admitting privileges at the "approved" hospital. Thus, a Medicaid beneficiary may receive prenatal care from a physician of her choice, but can find that this physician cannot perform the delivery.

- Finally, we must remember that the lowest cost institution does not necessarily provide services of similar quality to the higher cost one. For example, some hospitals may appear to have lower costs because they have aging plants or fewer nurses or underpaid staff.

H.R. 7028:

This amendment would provide that nothing in title XIX of the Social Security Act would be construed to prohibit a State from establishing a program under which relatives of Medicaid patients in nursing homes could contribute voluntarily to a fund for payment for their care under the State Medicaid plan. We oppose the proposal.

There is considerable potential for abuse in any proposal which allows States to solicit "voluntary" payment from families of Medicaid beneficiaries residing in nursing homes. It would be difficult to control against undue pressure and "arm twisting" for "voluntary" contributions, and difficult to prevent discrimination against beneficiaries who cannot produce such contributions. In fact, we have repeatedly encountered similar problems when nursing homes themselves seek "voluntary" contributions from relatives toward the basic costs of care for which patients are entitled to have payment made for them under the State Medicaid plan. In the past, there have been solicitation campaigns which appeared to be thinly veiled threats that, without such supplementation by relatives, the quality of care for the patient would be drastically reduced, or the relative would not be accepted as a patient at all. In

order to prevent such abuses, the Department's regulations do not permit Medicaid providers to accept payment from any source to supplement payment under the State Medicaid plan for the costs of care and services covered by Medicaid.

H.R. 7030: This proposal would facilitate termination of eligibility for medical assistance for individuals determined to have abused the Medicaid program. Currently such individuals' eligibility can be terminated upon conviction of criminal fraud or conversion with regards to Medicaid benefits. The amendment would permit such a suspension of benefits based merely upon an administrative hearing rather than a criminal conviction.

First of all, you must realize that, to the extent that there can be significant savings through fraud and abuse control, it will come from providers rather than beneficiaries. The potential opportunities available and dollars to be stolen are just much greater for providers than beneficiaries. We have considerable authority to address this problem in Section 1909(a) and the Fraud and Abuse Amendments of 1977 (P.L. 95-142). The Department is directing a substantial effort towards the problem of provider abuse.

Nonetheless, fraud and abuse by Medicaid recipients does happen and there is clear authority to address these circumstances.

- We are currently engaged in intensive efforts on Medicaid Quality Control -- aimed to reducing error rates in Medicaid eligibility and payments. These efforts are aimed, in part, at detecting cases of recipient fraud and assuring that Medicaid does not pay for these and other ineligible individuals.

- In the case of eligibility fraud, individuals who lie about their income can be immediately dropped from the program if they do not meet eligibility criteria. There is no authority for Federal reimbursement for payments for services to persons ineligible under the statute.

- In cases of chronic abuse or over utilization of services a State may seek a "lock-in" arrangement. This entails formal procedures under which individuals identified as chronic abusers select one primary care provider and/or pharmacist and then covered services and benefits are restricted to those delivered by such providers. This approach has been used successfully in several States and new legislation is not necessary for other States to take advantage of this useful control mechanism.

Not only is H.R. 7030 not necessary and not likely to produce significant savings; it could have a harmful impact particularly if a State wanted to use this mechanism to substantially reduce its Medicaid rolls. Since State administrative practices vary considerably, this provision would not adequately assure due process for the beneficiary. Beneficiaries may not have the same access to legal representation and due process protection at a hearing that they would receive during criminal proceedings. Thus, some innocent recipients might be unfairly deprived of benefits. We do not want cost savings at that price.

In conclusion, the Administration opposes all the amendments you are considering today. The potential harm far outweighs any cost-savings they might yield.

Thank you for the opportunity to appear before you. If you have any questions, I will be happy to answer them.

Mr. WAXMAN. Thank you very much for your testimony. We appreciate hearing your views.

The central issue on cost sharing, of one sort or another, is that whether it will discourage overutilization of the medical system, and eliminate all the costs that are related to that overutilization, or whether it will result in underutilization of needed care. But do poor people overutilize?

From your testimony, you seem to be saying that poor people see doctors less often than those who can otherwise afford to see them.

Dr. DAVIS. That is correct.

Mr. WAXMAN. How much of that would you ascribe to a cultural difference as opposed to an economic difference? How much of it is based on the economic reality that there is no copayment anyway, that the care is all being paid for? Why aren't the poor seeing physicians when it is necessary for them to see physicians?

Dr. DAVIS. Well, first of all, I think you have to differentiate those poor who are on medicaid and aren't lagging clearly behind average income persons in the use of physicians. But even among the poor on medicaid, there are selected services such as prenatal care or Pap smears where there is some lower utilization by medicaid recipients.

There are a number of barriers that even in the absence of copayment prevent medicaid recipients from getting necessary

care. Many physicians do not accept medicaid patients. In som
States, well under half of the physicians accept medicaid patient
In addition, physicians tend to locate their practices in relativel
well-to-do areas, suburban areas rather than in the inner city o
sparsely populated rural areas where many of these poor peopl
live.
It is true that while some of these individuals are unemploye
and therefore don't have to take time from work to seek medica
care, they have to undergo transportation expenses to receive car
They may have younger children at home so they have to arrang
for a sitter to care for those. So there are a host of barriers to car
that prevent the medicaid beneficiaries from overusing medica
services even in the absence of direct financial copayment.
Mr. WAXMAN. You describe those barriers that prevent the me
icaid eligibles from overusing the system. I gather that those wh
are poor but are not eligible for medicaid are using the syste
even less?
Dr. DAVIS. That is correct.
Mr. WAXMAN. We have most people up at one level, medicai
eligibles a notch below, and then the poor without a public healt
program down yet another level. Would it be fair to say that th
kinds of services that those on the medicaid rung do not hav
access to are preventive services? Do they go to a physician onl
when there is a crisis?
Dr. DAVIS. Overall, there is not that much of a gap in averag
physician visits. It is particularly the preventive kinds of service
that tend to get short shrift.
Mr. WAXMAN. How would you know that if the level of physicia
visits is the same?
Dr. DAVIS. We do have separate statistics on types of visits an
whether or not people get preventive services like Pap smears o
breast examinations or immunizations.
Mr. WAXMAN. So it is not solely an economic matter at all, it i
also a cultural matter that people don't go to the doctor if they ar
poor, even if it is being paid for, unless there is something that i
so urgent that they feel they have to take care of it? If it i
something off in the future they are most likely to defer it becaus
of these barriers to going to see a doctor even though the bill i
being paid for?
Dr. DAVIS. That is correct. There are barriers in addition t
economic ones that prevent their getting these types of service
Mr. WAXMAN. Dr. Willging, we heard from Dr. White from th
Alabama Legislature this morning a statement that nursing home
in Alabama charge medicaid patients sometimes up to $200
month in extra charges for laundry. Is this allowable under Feder
al regulations?
Dr. WILLGING. It has been allowable, Mr. Chairman. There hav
been discussions as to potential regulatory change which woul
make it clear that laundry services, especially for the medicai
population in nursing homes, which is essentially a living arrange
ment that extends for some considerable time, should be considere
a part of the basic rate and not be charged extra.
Mr. WAXMAN. So this is a unique situation where the nursin
homes are allowed to charge amounts over and above the medicai

rate, which is supposed to represent payment in full for all services given. They are able to charge above that for laundry?

Dr. WILLGING. Certainly our current regulations have been interpreted that way in certain States. We are looking into whether or not that regulation requires clarification.

Mr. WAXMAN. If they are being charged for laundry, and if relatives are able to pay for laundry, would that be an indication that there is money that can be contributed by the families?

Dr. WILLGING. I think that there are a couple of areas where there have been in effect allowances for payments above and beyond the basic rate. Those have been seen, however, by the Department to be in areas clearly other than that required for maintenance in the home, for the basic health care delivered in the home.

For example, there is already a provision which allows for such things as extra payment for private phones, television, that sort of thing. I think generally, however, the availability of outside income is not as prevalent as one would assume. The Alabama delegation suggested that a survey of the nursing home operators in that State thought there might be as many as 80 percent of the residents with relatives willing to contribute to their care.

The data we have—and suggests this is for all residents, not just medicaid—suggests that only 27 percent of the residents in these homes have anyone who is even available as a sponsor—that is, parents, spouses, or children. Only 7 to 12 percent appear to have sponsors with any income over $6,000.

So our data would suggest that there is indeed very little such residual income available, even if a sponsor were inclined to contribute voluntarily.

Mr. WAXMAN. If there are people willing to contribute, the only objection then would be that may be some element of coercion in setting up a voluntary fund?

Dr. DAVIS. We are concerned about that. There have been some instances where people have felt that unless they were to contribute their relative would not be given a nursing home bed. We are concerned about that.

Mr. WAXMAN. Can that be monitored?

Dr. DAVIS. With some difficulty it could be monitored but we found widespread instances even with current rules, where people have felt that they are contributing not truly voluntarily.

Mr. WAXMAN. Dr. Willging, Commissioner Kerns indicated in his testimony that Alabama over 7 months ago submitted to the Department regulations which would result in the elimination of otherwise unnecessary costs to the program. Without judging the substance of these proposed regulations, because I haven't seen them, it rather concerns me 7 months has elapsed without HHS having responded to them. Why haven't they heard from you?

Dr. WILLGING. Actually, depending upon how one defines response, I would suggest we responded essentially within 12 hours. The first time we had seen those proposals was in a meeting which the Governor of Alabama held with Secretary Harris. Immediately following that meeting, Mr. Kerns, I and Mr. Spiegelblatt of the Department sat down and went through that list item by item and provided our tentative suggestions.

Within 2 weeks after that meeting, Mr. Spiegelblatt submitted a letter to Mr. Kerns which I thought gave a fairly definitive view as to the practicality, feasibility, workability and legality of each and every one of those proposals.

Mr. WAXMAN. Some of the proposals are still pending for consideration?

Dr. WILLGING. Some of the proposals are pending. In a variety of forms, some of them are reflected in the amendments before this committee today. As Mr. Kerns suggested, a major one, on alternative hospital reimbursement plan, is about to be submitted to the Department for formal review. Some of them have, of course, been rejected by the Department. They include, for example, a proposal for physician copayment, which is precluded by statute.

My feeling is that for all of these proposals the State of Alabama is aware of the Department's position.

Mr. SHELBY. I think anyone would know where you stood from the tone of your voice and what you said. Don't you think you owe it to the State of Alabama or any other State, including the Governor, and members of the congressional delegation, if they are interested, to have a point-by-point discussion on it rather than a 12-hour deal, as you referred to?

Dr. WILLGING. Well, I certainly didn't mean to imply that it was that kind of——

Mr. SHELBY. You didn't mean, you just expressly said it, didn't you?

Dr. WILLGING. What in fact we have done is to spend considerable time both at the central office level and the regional office level with officials within the State. We believe some of the State's proposals do have some benefit—in particular, the alternative hospital reimbursement plan. We were quite anxious to review it and we have already discussed in some detail with the State ...ow such a plan might be structured so that when it does come into the Department, our formal review can be very expeditious and there need be no delay in terms of——

Mr. SHELBY. Is your basic thrust, though, you are not interested in any flexibility in a State's program?

Dr. WILLGING. Quite the opposite.

Mr. SHELBY. You are satisfied with the way the program is working, spiraling costs and everthing?

Dr. WILLGING. No, I don't think any of us, either at the State or Federal level, is satisfied with the way costs are spiraling. I think, as Dr. Davis indicated, however, most of these costs are not a result of the structure of the medicaid program but simply a result of the fact that the entire health care industry is suffering under heavy inflationary pressure.

What I think we have tried to do—although I would like the State to speak for itself as to whether we have been successful—is to work with Alabama in those areas where there might be immediate benefit to the State, the hospital reimbursement plan being one of them.

The State of Alabama does, however, have a well managed program. There have been no disputes about that, consequently, there are certain other quick fixes we are able to discuss with some States which do not pertain to Alabama. For example, its eligibility

error rates are already low. It already recovers very effectively from other third party payers.

Once again, I hope I did not create the impression we are not willing to work with the State in terms of what flexibility already exists, to try to pick those areas which we think promise likely benefits.

Mr. SHELBY. Do you have any suggestions as to other areas of flexibility that maybe we haven't suggested?

Dr. WILLGING. Well, there are——

Mr. SHELBY. It is in your bailiwick, isn't it?

Dr. WILLGING. It is, sir. The hospital reimbursement one is, I think, key. There are other areas. For example, the State of Alabama does not currently have an understanding with the AFDC program with respect to the absent fathers program. We think there might be some potential in this arena. I would be happy to supply a list for the record of a number of areas where we think there might be some potential.

Mr. SHELBY. When would you supply that?

Dr. WILLGING. I could supply that within a matter of days, sir.

Mr. SHELBY. Would you supply it to me along with the chairman and other members of the committee?

Dr. WILLGING. I would be happy to, sir.

[The following information was received for the record:]

ACTIONS (ALLOWABLE UNDER CURRENT LAW, REGULATIONS, AND PRACTICE) THAT ALABAMA COULD PURSUE TO CONTAIN COSTS

Third-party liability

The third-party liability initiative in Alabama does not seek out absent fathers. Alabama could enter into a contract with the Office of Child Support Enforcement (OCSE) under title IV-A.

Surgical procedures

Alabama could require prior authorization for elective surgical procedures. (Alabama has considered doing so for eight common procedures.)

Reimbursement for laboratory services

Alabama could—and has considered—reimbursing for all outpatient laboratory services at rates no greater than those charged by private (large automated) laboratories.

Drug costs in nursing homes

Alabama is exploring alternative methods for reimbursing drug costs in nursing homes.

Contracting with alternative delivery systems

Alabama could promote the use of more efficient and lower cost delivery systems, such as health maintenance organizations (HMOs), prepaid health plans, and community health centers.

Mr. SHELBY. Mr. Chairman, I would like to address a question to Dr. Davis.

Dr. Davis, I believe earlier in your testimony you said something about the figures supporting your claim that medicaid patients use health care less. Did you say something to that effect?

Dr. DAVIS. That is correct.

Mr. SHELBY. Where did this data come from? What is the basis of that?

Dr. DAVIS. The principal data source is the health interview survey run by the National Center for Health Statistics.

Mr. SHELBY. When was this done?

Dr. DAVIS. This is done annually. The most recent data are for 1977.

Mr. SHELBY. Who did it?

Dr. DAVIS. This is conducted by the National Center for Health Statistics which is part of the Department of Health and Human Services.

Mr. SHELBY. In other words, it was done in-house?

Dr. DAVIS. Yes, sir. I also have data that came out of the Rand Corp. They have gone into six geographic areas doing baseline studies on the services.

Mr. SHELBY. How do the Rand figures compare with your own?

Dr. DAVIS. They stack up very, very similarly in that respect; namely, that if you look at poor people as a whole, they use slightly less physician services than the average population. You look at those who are uninsured, they lag behind all others in use of services. If you look at the medicaid population, they are behind overall, although they lag behind in some services particularly.

Mr. SHELBY. Do you have a demographic breakdown on all of this?

Dr. DAVIS. Yes, the sample size for the health interview survey is fairly large. There are about 150,000 who are surveyed there. It doesn't give you a breakdown by State but does have data by race or age.

Mr. SHELBY. Do you have any suggestions based on your educational background and your present position on any types of flexibility that could be injected into the medicaid program, not just for Alabama but the whole thing? We are dealing with the whole Nation.

Dr. DAVIS. I think as Mr. Willging indicated, the primary problem really is that health care costs for everyone, not just the poor or medicaid beneficiaries, are going up at great rapid rates. Hospital costs in the last few months have started going up again at about 15 or 16 percent a year, and this is being reflected in our medicare budget, our medicaid budget, as well as employer health insurance premiums and out-of-pocket payments by the entire population.

So we think it is extremely important that we bring about some meaningful restraint on increases in hospital costs either through some form of national legislation or setting up State cost commissions that would try to hold down the rate of increases in hospital costs across all kinds of payers.

In addition, to talk about the medicaid program specifically, we think there are ways in which the States could promote use of more efficient delivery systems such as health maintenance organizations when the States do have HMO's, or lower cost community health centers in the state. We would encourage the State medicaid programs to contract with those organizations and encourage medicaid beneficiaries to enroll in them.

There are a number of things that could be done through the PSRO programs such as more extensive review of length of stay, perhaps prior administration review of elective surgery, looking at utilization in that area.

Dr. Willging has indicated some of the administrative improvements that could be made generally for States that have room for

management improvements such as reducing error rates and increasing payments from those individuals who happen to have both medicaid and private insurance, collecting payments by private insurance companies.

Mr. SHELBY. Are other States experimenting on problems with the medicaid funding?

Dr. DAVIS. Increases in medicaid costs are a national problem.

Mr. SHELBY. So it is not just an Alabama problem?

Dr. DAVIS. No, it is not. It is going up very rapidly across the board.

Mr. SHELBY. Thank you, Mr. Chairman.

Mr. WAXMAN. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I certainly appreciated your presentation very much today. I am happy to see you here.

One suggestion that I have had, and there are many, many things that I find that are really not as they should be with the medicaid system, and of course anyone who is on welfare in my State and I suppose in other States is also on medicaid. Those who are on SSI, supplemental security income, are also on medicaid, aid to families with dependent children, and so on.

However, included among this number is an inordinate number of people who should be working, and I would like some way to get this number out, who are able to work. Everyone who can work should. In order to do that, after talking with people who work in the Department of Human Resources in the State of Kentucky, they tell me they have a lot more people there than they need, perhaps two or three times as many.

All of us are paying for it. In Kentucky it is about three-fourths, I believe, financed by the Federal Government. There is a way to really reduce the number of ineligibles, those who actually shouldn't be getting medicaid but should be working.

What do you think of a board of five people, say a physician, a clergyman, and three other citizens in each ward or each magisterial district to voluntarily pass on the eligibility of these people? What do you think of that suggestion?

Dr. DAVIS. I think it is a serious problem when people who are able to work can't find jobs. I think if you look at the medicaid program——

Mr. CARTER. On Medicaid and can't find jobs? They can find plenty of jobs where I come from, and really we just can't get some of these people to work. That is one of the problems.

Dr. DAVIS. It may vary from place to place, but I think nationwide we are all aware that unemployment is running about 7.6 percent, and about 8 million people.

Mr. CARTER. 7.9. I believe it went down 200,000.

Dr. DAVIS. I think the trend has been down in the last months.

Mr. CARTER. Slightly.

Dr. DAVIS. In periods of rising unemployment the medicaid rolls do go up. In the period of a very hard, sharp increase in unemployment from the fall of 1974 to the spring of 1975, medicaid enrollment went up 25 percent.

Mr. CARTER. What do you think of this?

Dr. DAVIS. We do have national economic problems. There is a problem. To address your specific proposal, I think it is important that we have some standards about what is deemed adequate income for people to take care of their own medical expenses. Currently, the States set overall income limits that is at the discretion of the States. Some States set them very low, but I think it would bother me to say that some group could decide that even if a family's income was $1,000 a year, that they weren't eligible for medical assistance.

Mr. CARTER. I don't think they would do that if you have a board, such as I suggested, of well-meaning people, and that is the only type you would have on such a board to pass on their eligibility.

Another thing that bothers me about this program, and I get this directly from the people who are in the work of determining who gets medicaid, and that is that if an illiterate comes in and the way they test his IQ is that he is always or practically always placed on medicaid, welfare, and therefore medicaid in addition, when actually these people could be well employed and have been employed over the years.

Do you like that way of doing things? Should a person who is illiterate always be on welfare and medicaid?

Dr. DAVIS. I believe very strongly that for anyone who wants a job and is capable of holding a job, that we should try to make jobs available to those people. I think the bulk of these individuals would like to work.

Mr. CARTER. And you don't think that fair, well meaning people in each area then should be the judge? You know everyone in this group, there is not a person here who wants to deny aid to anyone who needs it? Would any one of us do that?

Dr. DAVIS. I would certainly hope not, but I think it is important to assure that that applies uniformly.

Mr. CARTER. I wouldn't think so.

Would you have those five people make this judgment, or would you have one person employed there in this particular department, aid to families with dependent children, for instance, make that decision, when that decision means, if he or she makes enough of them, more assuredness of her job?

Dr. DAVIS. I don't think it should be an arbitrary decision of one individual or a panel of five individuals. I think it is the responsibility of the Congress and the President to establish clear-cut rules about who should be eligible, and those rules should be followed.

Mr. CARTER. That is what we are trying to do today, part of it. We want due care, but I am pointing out that this would be at the point where the delivery is. I have talked to these people. They tell me that they have two or three times as many people employed at the local level as they should have, with ample coffee breaks and a lot of fun going on. These are things that we have got to get rid of.

Not only that. I have some people that I regret to say that are on food stamps which is a little bit different, but they have become so obese as a result of it that they are actually disabled. I think that we have got to do something. These things demand, as I see it, they demand attention. I don't want to deny, as I said, aid to anyone who needs it.

Furthermore, during our August recess for the convention, I happen to have farm land, and I tried as I frequently do myself to do stoop labor, and I mean just that, going out, pulling weeds, working with a hoe and such things as that, and I didn't find it a bit degrading. In fact, I think that the people of this country are going to have to return to working, to not be afraid of the sun and heat. We have got to have the grit to work, but we are losing many of these people. They are becoming second and third generation welfare recipients when they could work.

I hope and trust that we will do something to get them back to work. I feel they will be happier and healthier definitely, and I can cite you the cases I have told you about, the patients who have been on food stamps and have become so obese that they are now disabled.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Gramm?

Mr. GRAMM. Thank you, Mr. Chairman.

I can't help but just throw in my 2 cents worth at the end of Dr. Carter's statements. We in Texas 3 years ago cut welfare, heartless though it was. It was very popular in my State. The Governor cut welfare and miraculously we had the largest increase in the labor force in the history of Texas. We had a substantial increase in employment by those who before had been deemed unemployable, and within 4 years our welfare levels were back above the levels that initially existed prior to the cut, and a very small percentage of those who had gone off welfare to take jobs initially had come back on when the welfare gravey train pulled back up to the station.

So I would like to just share or identify myself with the statements of the gentleman from Kentucky. What we have done with these welfare programs is we have seduced a whole generation of Americans. They have not gone out and worked in the sun and pulled weeds because they hadn't had to do it. There were good alternatives available and we denied them a part of the American dream and they are the real victims, not the poor sap who has to work to pay the bills but the people who have just never gotten to be a part of the system because there is a whole bureaucracy here that feeds off playing God in dealing with these people.

I thought Mr. Dannemeyer's statement was pretty extreme and awfully partisan until I listened to your statement. I am afraid he is right. I have heard every liberal cliche which has been totally destroyed by the facts of the last decade referred to here. We have got to find these people jobs. I could bring you 10 pages from the classified ads in Houston, Tex. of this Sunday of people begging for people to come to work.

Granted, if I am an auto mechanic in Detroit, Mich., I can't find a job in Detroit, Mich., but if I am willing to get up and move I can find a job in Houston, Tex.

The point is we have set up a system that destroys people's incentives to move, but I don't want to get into that whole thing.

I would like to talk about poor people and medical care, because I am not overwhelmed by your statistics.

First of all, I would like to talk about the working poor utilization versus those that are on medicaid. Do we have data on that, or

people who are poor who are not on medicaid using medical services less than people who are on medicaid?

Dr. DAVIS. We do have some statistics on that. Again, with all these statistics, I think to make comparisons you have to make some adjustments for differences in their health status. But if you look at those poor who are not on medicaid, you do find, for example that the uninsured poor, just comparing them with the poor, run anywhere from 15 to 45 percent below physician visits by those poor who are on medicaid, making these adjustments for differences in health status. That comes from three different studies, but they all tell us about the same thing, that is, National Center for Health Statistics, a survey at the University of Chicago Center for Health Administration Studies and the Rand Corp. study that I mentioned before.

Mr. GRAMM. So these are people that are working, that are earning some income, that is, getting them above the eligiblity level, and they are getting less care than the people who aren't working who are qualified?

Dr. DAVIS. These individuals do not necessarily have higher incomes than individuals on medicaid. In the State of Texas, for example, only 1 out of 10 poor people is covered by the medicaid program because it does not cover two parent families.

So basically to be covered under the medicaid program it is not just an income test but also a family definition test, that it will cover aged individuals, blind and disabled individuals or one parent families, but you can have two-parent families at very low income levels that won't be covered under medicaid.

Mr. GRAMM. Let me ask you a question. Do you have data on people who, say, make between $6,000 and $10,000, that relative bracket, as compared to people on medicaid, as to utilization?

Dr. DAVIS. Yes, we do.

Mr. GRAMM. And what is this utilization?

Dr. DAVIS. If you look at people with incomes of about 100 to 200 percent of poverty which would be about $7,000 to $15,000 income and adjust that for health status, their utilization is about 1½ times that of those underneath the poverty level.

Mr. GRAMM. How do you adjust that data for health status?

Dr. DAVIS. There are several ways. This particular data source, which is the National Center for Health Statistics, looks at their use relative to the incidence of bed disability days, numbers of days in which people are confined to beds. The Rand Corp. has done it using econometric techniques, adjusting for health status. So different organizations have used different techniques, but they come up with roughly the same kinds of results.

Mr. GRAMM. Let me ask you one more question relating to statistics. I don't doubt that there are poor people who because of lack of information or lack of experience in using medical services don't use them very much, but what do we know about the distribution? Does the distribution of usage indicate that there are individuals who are high level users, even though the average might be low, that there are those who become skilled consumers in consuming these services?

Dr. DAVIS. There has been some instance of so-called doctor shopping or medicaid beneficiaries who have gone to a number of

different physicians for the same illness, or maybe even different pharmacists, and as we have indicated, there are procedures that the medicaid program can use to deal with this.

For example, a lock-in procedure whereby a medicaid beneficiary can only go to one named physician or one named pharmacy. The State of Alabama does this. They now have 10 individuals in the entire State that they have put on this lock-in system, so it exists. It is not comparable to the 4,200 or so population on medicaid.

Mr. GRAMM. But statistics do indicate that even though the average is low, that there may be those who, lacking any knowledge about their clear medical status, that they may be abusers?

Dr. DAVIS. Yes, although the data seem to indicate that it is less than one-tenth of 1 percent of the entire population.

Mr. GRAMM. I would like to get your response, and I think I know what it is but I want to get it, to the following quandary that your position on this leaves us in.

You are saying, don't force poor people to engage in coinsurance payments even though the coinsurance payment may be low relative to their receipt of a welfare payment or dole, but at the same time we know that working people, and I think a small independent trucker who is not a member of a union, who does jobs on a consignment basis, might very well not have health insurance. He is working 60 hours a week, and he is earning $12,000 a year. His wife may be doing part-time work and she may not be covered. They face very real economic impediments to entering the medical care market.

It doesn't mean they don't enter. It doesn't mean they face the same impediments, but maybe they ought not to. Maybe people who aren't working ought to face slightly higher impediments. But all that aside, those people do face impediments and you are arguing against a coinsurance payment of even a nominal amount on the nonworking poor that are covered by medicaid.

Now, how do you rationalize those things, given that we have the guy out there in society who is working very hard to make ends meet, and that guy has got to pay the full price, and we have got a person who maybe can't find a job. I am sure there are people in that category. I am afraid that my sentiments induce me to believe that there are far fewer of those than we tend to perceive in Washington, but that aside, how do you rationalize the treatment of the guy who is working, who is trying to make it, versus the guy who is not trying to make it or can't make it?

Dr. DAVIS. I think you have raised a number of problems there. I think you have to look at these in some order of priority.

I think first of all you have to look at the poor population, and I think the first serious problem are those poor who aren't covered by medicaid at all. About half of the poor are not covered by medicaid, and for those individuals to try to pay the costs of their medical care is a serious problem. We ought to be expanding medicaid eligibility or national health insurance.

Mr. GRAMM. So your solution is to bring these other people into this system where they don't have to pay the coinsurance?

Dr. DAVIS. I think that what we found from the medicaid experiment in California, that if you have individuals whose incomes are $30, $40, $50 a week paying a $2 physician copayment, it does deter

their getting very necessary medical services such as immunization, family planning services, and does increase their hospitalization. So I don't think we should be imposing copayments on individuals with very low incomes.

Mr. GRAMM. The problem, of course, with your proposal that we broaden the coverage is that we are having trouble paying for the people that we are already covering.

Dr. DAVIS. That is true.

Mr. GRAMM. I guess your answer to that would be cost controls. You know the paradox is, and I will end on this, Mr. Chairman, that we sit here in this debate and HEW or HHS talks about taking care of people, a very paternalistic viewpoint, portrayed as really the good guys, but at the same time you are proposing programs, cost containment programs which are really rationing programs. Hospital cost containment is really a rationing program with health care.

There is sort of a paradox here. What has happened here in the name of doing all this good, we have set up programs where the incentive is for people to buy more, more than we can produce. Costs rise, that is where the medical cost is coming from, increased demand, and so your response is a response which is to limit the care that is provided, to ration care, and I don't see that that is any less restrictive.

In fact, it may be more restrictive than an effort which is targeted toward limiting demand by imposing some nominal coinsurance payment. At least in the limiting of demand people get to choose.

If you are rationing supply, people in a moderate-sized town in the South who don't already have neonatal units, that don't have emergency units, would never get them under hospital cost containment which the Congress fortunately defeated, but in both cases we are talking about limiting access to care.

Mr. WAXMAN. Would the gentleman yield?

Mr. GRAMM. I would be happy to yield.

Mr. WAXMAN. In either case, we are talking about rationing care because we are saying that not everybody is going to get all the care they may need in terms of medical judgment of what they may need. In the case of putting copayments on poor people, we may then be saying to them that if they have to make a choice between lunch for their kids and going to a doctor, they are going to be prevented from getting care by making what under the circumstances is the rational choice. If it is not an emergency and the kid is not dying, they just don't take him in for care that may prevent an illness from getting to be a lot more expensive and costly both in terms of dollars and in terms of human life and suffering.

It strikes me that we are faced with a system that is costing us too much, and we are trying to tinker with it. What proponents of cost-sharing want to do is to tinker with it at the expense of the poor as opposed to tinkering with it at the expense of the providers, who may not be the most disadvantaged in our society.

Mr. GRAMM. Mr. Chairman, I don't think when we are talking about cost incentives that we are talking about tinkering. We are talking about the most proven system of allocation efficiency which mankind has ever developed in the whole history of our knowledge

about why people buy things, why they conserve, and I just know my grandmother used to say if something is very scarce, the last thing you want to do is give it away, but in fact that is exactly what we have done in terms of health care. And I am not denying that coinsurance payments force people to make hard decisions, but I would like to just end with two points and I appreciate your tolerance on the time.

These decisions are already being made. There are people in this country that are working who are paying these taxes to provide these programs, where paying those taxes takes things away from their children, including their ability to get medical care. These things aren't free.

No. 2, I think that these coinsurance payments can be scaled down, and while I am totally in favor of medical education and getting information out to people, I have to say that I have a very basic bias that induces me, where we have got to conserve something, in this case medical care and medical resources, that I would rather let people choose and make hard sacrificing decisions than I would to have people choose for them, and therefore deny them the opportunity in some cases of making the choice.

I don't buy the idea that these people are completely ignorant, that they can't make rational decisions. I think many of them can make rational decisions. I think the ability of the few to abuse the system shows a sophistication which induces me to believe they could find gainful employment.

Mr. WAXMAN. Would the gentleman yield for one point?

Mr. GRAMM. I would be happy to.

Mr. WAXMAN. A famous French author once said the rich and the poor each have a choice as to whether to sleep under bridges. Unfortunately, I think the choice is not the same one for the poor and the rich. Only the poor sleep under bridges; the rich can find an alternative.

What you are talking about sounds right as an abstract economic model, but I think you ought to see what a poor family goes through trying to rearrange its schedule to get over to see a doctor. I think that the barriers are there. I really don't, quite frankly, believe that a copayment is going to be a rational way to decide whether a poor person will properly use the medical care system.

Mr. GRAMM. Mr. Chairman, if I may conclude, I don't think I am talking about an abstract economic model. I am talking about working poor today who are making hard decisions, and I am saying that those who are riding in the wagon ought not to fare better than the people that are pulling the wagon.

No. 2, I am not talking from abstract logic. My parents lived in a government housing project when I was born. I didn't go to the dentist until I was 16 years old, so I think I know something about poverty, and so I don't view this—it is not that I have never seen a poor person. I would like, harsh as this may sound, to state there is a built-in element in this whole debate that people are poor or rich by accident. It is sort of like the Joan Baez song talking about this poor guy walking down the road, "There but for fortune go you or ."

I reject that. There are some people that are poor because they are sick, and because they don't have the basic ability to compete,

but there are very many people who have overcome obstacles and do achieve, and I don't buy the idea that it is simply random, that Dr. Davis is sitting there because she is lucky. She could have just as well been on welfare. I doubt that.

I think that there are some basic distinctions as to people who are poor and those who aren't, and I think there are many people where there is a choice or an incentive or an element of drive present, and I just don't like the idea of always penalizing the guy who is pulling the wagon to benefit the guy who is riding in it when there are some who are riding there by choice, not all of them but some.

Mr. WAXMAN. I thank the gentleman.

Mr. Dannemeyer?

Mr. DANNEMEYER. Thank you.

I would like to know if either one of the panelists watch "60 Minutes"? Did you see the program last night?

Dr. WILLGING. For the second time, sir.

Mr. DANNEMEYER. Did you see the one about dear Dr. Rubin in my home State of California?

Dr. WILLGING. Yes; I did.

Mr. DANNEMEYER. Did you see it, Dr. Davis?

Dr. DAVIS. I didn't see it last night. I did see it before.

Mr. DANNEMEYER. It was interesting because it was the second time I have seen it as well. It was Dr. Rubin and the program related to this matter of copayment. His office allegedly makes a distinction between the treatment of people in need of medical care as opposed to those who pay and those who have insurance or are covered by some Federal-State program. But, when two citizens, both of them healthy, walked in off the street, complaining about a cold, here is what happened.

The one who was covered by medicaid was diagnosed as having a cold and possible meningitis. The one who was paying cash was diagnosed as having just a cold. The one who was paying cash got very nominal treatment for a nominal charge and that was it. The one who was covered by medicaid, and was diagnosed as having both a cold and possible meningitis, was put in a hospital overnight, for tests, to determine if there was something further there that needed to be attended to.

Fortunately, for the sake of the recovery of the victim, the patient, there was no meningitis. However, the bill came to about $200.

Mr. WAXMAN. Will the gentleman yield?

Mr. DANNEMEYER. I will yield in just a moment.

Apparently, there have been efforts made to investigate the status of dear Dr. Rubin. But the Government has been frustrated in its efforts to investigate this distinguished gentleman.

Perhaps the spirit will move someone sufficiently to cause him to be investigated. If I could move that spirit along, I would be happy to close, but you have expressed concern for inflation, the impact or the suggestion being that we need cost containment.

The most constructive thing that this Congress can do in terms of inflation is deal with the basic cause and the cause is the irresponsibility of this institution in spending year after year more

than the IRS collects from people we have the courage to levy taxes on.

The balance is just printed dollars inflation, and the irony and the cruelty of the whole system is that we do it all in the name of helping the poor, the downtrodden, and those who can't help themselves. They are the earliest victims of this inflation because it impacts most adversely upon those in the lower economic scale.

I will come back to my thought that apparently touched the funny bone of my distinguished colleague from Texas, Mr. Gramm, who thinks my arguments are extreme.

With all due respect to the work quality of the members of the panel that you are contributing toward liberation, some of us are working diligently to replace you because we think other people would come in here and recommend these fine proposed programs of the gentleman from Alabama; frankly, we think, from the standpoint of the taxpayers time has come for the programs he is talking about. We need to introduce a new element into this whole subject, such as coinsurance, which is probably one of the most constructive small things we could introduce, given what I related about Dr. Rubin.

As the provider of the service, apparently he has more difficulty in taking advantage of it when somebody has to pay than if they have to pay, and that is something that needs to be addressed.

I will be happy to yield.

Mr. WAXMAN. The point I was going to raise was that I happened to watch the show last night. The situation you describe is not one where the patient is abusing the system. Instead, the provider of the service is abusing the system. If the patient has insurance—now that could be private insurance as well as Government insurance—a dishonest doctor or hospital administrator is going to try to squeeze as much money as possible out of that person.

If we subjected that patient to a copayment, that patient may not have shown up at all for medical treatment. But that wouldn't have prevented Dr. Rubin, should all these allegations have been true, from charging for services that either should not have been provided or were not in fact provided to whomever came to him who had insurance coverage.

Mr. DANNEMEYER. Maybe I didn't make myself clear. The point is that if we have a tendency on the part of health providers to overprovide, if the recipient of the service has to put up some of the money, apparently it acts as a deterrent to the provider who has a tendency to overprovide. As a taxpayer, I think I come out ahead. I like that.

Mr. WAXMAN. In that show it was alleged that providers were collecting from Medi-Cal, the medicaid program in California, recipient's money, which by law they are not allowed to do. So they were getting their copayment from these recipients. The patients were still coming to the doctor because they felt there was a need to go to the doctor. They must have been in pain. It wasn't because they wanted to see him. Then the providers were billing the Government extensively and the Government was paying. So I don't know that if you passed a bill like this to allow copayments you would do anything to prevent fraud and abuse of the system by the providers.

Mr. CARTER. Mr. Chairman?

Mr. WAXMAN. Dr. Carter?

Mr. CARTER. I have a question about California.

Mr. WAXMAN. We all have questions about California.

Mr. CARTER. I think it is a great State. I have nothing bad to say about it.

Mr. WAXMAN. We don't either.

Mr. CARTER. In the study done on copayments in California, someone may have asked this, I don't know, what I would like to know is how in analyzing the study one can be sure that the observed increase in total health care costs can be attributed to copayments and not to some other factor or factors?

Dr. DAVIS. The study did find, as I indicated, that ambulatory visits went down about 8 percent, and hospitals went up about 17 percent. Overall that resulted in an increase in program costs of about 3 to 8 percent. That particular study said about the same or slight increase, but didn't make a strong assertion that there was a major increase in cost, but that it was clear there weren't savings.

Mr. CARTER. If I may proceed, I still believe that we need a board in each area to check these people, and to be sure that those who deserve to received medicaid do, but regretfully I say——

Mr. DANNEMEYER. May I add a comment to that if the gentleman will yield?

Mr. CARTER. In just a second if I may finish.

I can't agree with the copayment thing because I think that would be denying health care to someone who might desperately need it, and you wouldn't deny that, Bill, I wouldn't think.

Mr. DANNEMEYER. The idea of a board is valid so long as there is knowledge, direct or indirect, on the part of the board members about the group or the individual whom they are considering. From your perspective, from what I understand about your roots in Kentucky, you come from a small county.

Mr. CARTER. Yes, sir.

Mr. DANNEMEYER. Where people have a tendency to know one another?

Mr. CARTER. Yes, sir.

Mr. DANNEMEYER. The board in that setting would work well. In an urban area from which I come, where people move at a rate that defies human understanding, for a board to function there, frankly, the result would be an analysis of recommendations from staff establishing eligibility. There would be little knowledge on the part of the board members of the perspective or the subjects, and it would be a useless exercise.

Mr. CARTER. It is my understanding now that people who are really not known can go to a post office and ask for food stamps and be given them without having been known. A stranger just passing by can go in and get as much as $30 at one time. I believe my postmaster told me that just in the past few weeks.

I would hope that the person would be in need if that is the case. Certainly I think those things need to be studied and handled with care.

Mr. WAXMAN. We have other witnesses to appear on these series of bills. We are going to break now and return at 2 p.m.

[Whereupon, at 12:40 p.m., the subcommittee recessed, to reconvene at 2 p.m. the same day.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Henry A. Waxman, chairman, presiding.]

Mr. WAXMAN. I would like to now call forward a panel consisting of LaNita Bennett, Legal Services Corp. of Alabama, accompanied by Mildred Brown; Spiver W. Gordon, Alabama Coalition Against Hunger; Judith G. Waxman, National Health Law Program; Betty Hamburger, National Citizens' Coalition for Nursing Home Reform, accompanied by Toby Edelman, National Senior Citizens' Law Center.

I would like to welcome you all to this hearing. I believe the order you want to proceed in is to have Judith Waxman, my namesake, proceed first.

Please go ahead, and if we have statements from you, we will make those statements part of the record in their entirety. We would appreciate your summarizing those statements.

STATEMENTS OF JUDITH G. WAXMAN, ON BEHALF OF NATIONAL HEALTH LAW PROGRAM, INC.; LaNITA A. BENNETT, PARALEGAL, LEGAL SERVICES CORP. OF ALABAMA; MILDRED BROWN, ANNISTON, ALA.; SPIVER W. GORDON, BOARD MEMBER, SOUTHERN CHRISTIAN LEADERSHIP CONFERENCE; AND BETTY K. HAMBURGER, ON BEHALF OF NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM, ACCOMPANIED BY TOBY EDELMAN, STAFF COUNSEL, NATIONAL SENIOR CITIZENS LAW CENTER

Ms. WAXMAN. Mr. Chairman, I am Judith Waxman and I represent the National Health Law Program. This is a support center funded by the Legal Services Corp.

We provide professional advice and assistance to lawyers and legal advocates around the country on matters concerning health care access for poor people.

We have extensive contact therefore with the poor on health issues, and particularly in the medicaid area. Based on our experience, it is our view that H.R. 7029 and H.R. 7030 allow dangerous and harmful restrictions on access to health care.

I would like to deal with each bill separately.

H.R. 7029, which authorizies copayment for mandatory services, for categorical assistance recipients—they are the people on AFDC and SSI—undermines the fundamental purpose of the Medicaid Act. Medicaid was created to provide access to medical services for people who have little or no resources.

The result of copayments would be to deny poor people crucial medically necessary health care. Not only would copayments result in untold physical and emotional suffering, but also copayments do not distinguish between those services that are medically necessary and those that are not necessary. Other legitimate utilization controls that are available can make this distinction.

The impact on these recipients is very substantial. Categorical assistance recipients simply cannot afford these copayments. Recipients will have to fund their copayments from amounts deemed minimally necessary for food, clothing, and rent. It has been mentioned earlier this morning that many times States do not even pay

the amounts for the individual that the State itself determine be necessary for basic necessities. Individuals further deplete sustaining resources for health care.

Sometimes it is hard for middle-class people to comprehend w a minimum copayment would mean to the very poor. Most An cans I would say would not really delay a visit to the docto delay buying a prescription for 50 cents or $1, but that is just w a copayment would do for the very poor. It will force them to d or avoid doctor visits, or else force the loss of another neces

I have a couple of examples to illustrate this point.

A couple that was our client in Texas tried to enter a c recently. The wife had been coughing and had congestion for se al days. The facility had a $3 fee that had to be paid before could get in the door. The man had 18 cents in his pocket, and are turned away. His wife died 2 days later of do pneumonia.

A 41-year-old man who was our client had Parkinson's dise He needed extensive medical services. He needed services from doctor at least two times a month and prescriptions. Out of $312.50 a month he had to support his wife, his daughter, and entire household. He could not afford dental work that he ne and that his daughter needed. He couldn't have his car fixed o appliances fixed, and he certainly could not afford copaym

Proponents of copayments say that copayments will curtail necessary health care utilization and contain costs. Studies do support this. There is a classic study, however, that does show w the effect of copayments are and they are these three:

One, a reduction in needed health care; two, an ultimate incr in costs and, three, may lead to a reduction in the provi

The study which was mentioned this morning, took place 1972 to 1973 when California conducted an experiment in w they added copayments to doctor visits and on drugs. The s was conducted by Dr. Milton Roemer of UCLA along with associates.

His article that reports the results of the study is called "P Wise and Pound Foolish," and that pretty much sums up wha found.

I have submitted with my testimony for the record a copy of article and also a statement from Dr. Roemer stating that not has happened in the intervening years to change his view. [See 107 and 110.]

The study showed that copayments cause an inhibiting effec the receipt of health care and that the inhibiting effect hap regardless of the need or the care. What Dr. Roemer did compare the patterns of health care for recipients before, du and after the California experiment. He compared two grou people. One group paid the copayments and the second grou not pay the copayments.

The study demonstrated that while ambulatory care utliliz was less for the group that paid copayments, their hospitaliz and attendant higher costs increased dramatically. As Dr. Ro stated, "It's likely that this elevated hospitalization rate is du the postponement of ambulatory care so that when a patie finally driven to seek assistance his case is more advanced."

The study concluded that this experiment cost California an additional $1,228,150. Medical copayments bring short-term reductions in expenses, not because they ferret out unnecessary utilization but because they prevent needy people from getting necessary care.

In the long run in addition to the pain and suffering, they result in an increase in more expensive forms of care. For these reasons we are opposed to the enactment of H.R. 7029.

H.R. 7030; this bill amends the Medicaid Act to provide that if a person is convicted in an administrative hearing, among other things, of knowingly and willfully making false statements or material facts in application or for use in determining benefits, medicaid benefits can be restricted or suspended up to 1 year. Additionally, it lowers the standard of proof to a "preponderance of the evidence."

This bill represents an unwarranted and dangerous extension of the State's power to adjudicate alleged misconduct and suspend medicaid eligibility, in an area where the standard of proof and protection of a criminal proceeding should apply. To deny an individual the protections of the beyond a reasonable doubt standard when the individual is accused of knowingly and willfully making false statements and representations would lead to untold numbers of innocent people being unfairly punished.

Furthermore, because there are many procedural inadequacies that are frequently found in State's fair hearing procedures, an administrative hearing is inappropriate. Examples of such inadequacies are the State not giving the recipient a reason for the denial or the State not giving notice as to what standards should be used in determining eligibility. These examples make the protections and standard of proof in a criminal proceeding more apparent.

I do want to emphasize that medicaid eligibility determinations are made through a large array of regulations and policies, the interpretation of which is often unclear. One judge noted that medicaid regulations "have a complexity which make them almost unintelligible to the uninitiated."

There is a considerable chance for honest error both on the part of the recipient and on the part of the State.

In fact, in 1979 HEW did a study that showed there were 268,000 erroneous denials of benefits in AFDC cases in 6 months in 1977. Given these circumstances, and the high penalty, an obvious substantial proof standard should be used to confirm that errors were knowingly and willfully fraudulent.

Since its inception, medicaid required the beyond a reasonable doubt standard to be incorporated in criminal proceedings. It's additionally unconscionable to reduce the standard in light of arbitrary decisions that States demonstrate in administrative procedures.

One example is of the 65-year-old woman in Virginia who was partially blind and deaf and had a nervous condition. She shared ownership in a parcel of land with 27 relatives. She had inherited one-seventh share in three different parcels of land. She reported on her application the tax assessed value of the land and this amount exceeded the resource level for medicaid eligibility. There-

fore she was turned down, even though the Federal law required that the resources used in determining eligibility actually be available to her.

In another instance, when a New York man transferred property to his mother to pay a debt, and 2 years later he was shot in the head and he sought medicaid, the State agency found that he transferred the property simply to lower his resources so that he could qualify for medicaid.

Applicants and recipients are frequently shocked to learn that the income and resources that they did not consider available to them are considered available to them by the State agency.

These recipients might not report such resources, and be liable under this lower proof standard to a fraud conviction, and a year's medicaid disqualification.

One other fact for consideration is that there is some evidence to conclude that the creation of this remedy may be a redundancy.

The Food Stamp Act gives authority for both administrative and court proceeding to adjudicate fraud. Experience has shown that States rarely use the administrative hearing. In fact, the House Agriculture Committee reported that it was not used even when the Department advised States that it was a mandatory responsibility for them to do so.

The committee said that States reported that the expense of an administrative proceedings was wasteful. States were concerned that a civil proceeding might jeopardize individual constitutional rights, and also they questioned whether or not they had adequate staff to hold administrative proceedings.

It's reasonable to assume, that States similarly would not utilize an administrative proceeding if such a proceeding would be established for medicaid. If States would opt for the administrative proceeding, it would be primarily because the proof of fraud would be easier.

If there is another legitimate reason, then a remedy could be fashioned that does not threaten the recipient's interest. H.R. 7030, however, does not afford adequate protection, and we urge emphatically that it not be enacted. Thank you.

[Testimony resumes on p. 120.]

[Ms. Waxman's prepared statement and attachments follow:]

Testimony of

The National Health Law Program

before the

Subcommittee on Health and the Environment

House Committee on Interstate and Foreign Commerce

The National Health Law Program, Inc. ("NHeLP") submits this testimony in opposition to two of the Bills before you today: H.R. 7029, which would authorize copayments on basic Medicaid services; and H.R. 7030, which would radically extend states' abilities to terminate individuals' Medicaid eligibility. We are appearing here today with a panel of Medicaid recipients and health care advocates from the State of Alabama who oppose these measures. In addition we are submitting with this testimony a statement and materials by professor Milton I. Roemer of the University of California at Los Angeles, an internationally respected public health expert, in opposition to H.R. 7029.

NHeLP is a health law support center funded by the Legal Services Corporation to provide professional advice and assistance to legal services advocates and their clients. We have extensive and ongoing contact with poor people and their representatives throughout the country regarding a variety of health subjects, including Medicaid, which are of vital concern to them. This testimony is presented pursuant to 45 C.F.R. 1612.4.

Based on our experience in providing professional assistance to clients and our extensive knowledge of the Medicaid program, it is our view that H.R. 7029 and 7030 represent dangerous and harmful restrictions on poor peoples' access to medically necessary health care. The following comments explain that position.

H.R. 7029

The fundamental purpose of the Medicaid program is to provide necessary medical care for poor people who could not otherwise

afford it. Accordingly, from the inception of the program, all recipients of categorical assistance---AFDC and [now] SSI---have been mandatorily eligible for Medicaid. Furthermore, categorical assistance recipients have always been exempted from copayment charges for those crucial medical services [designated in 42 U.S.C. 1396d (a)(1) to (5)] which all states must as an irreducible minimum include in their Medicaid program. These are referred to as the "mandatory" services.* The basis for this exemption was the recognition that categorical assistance recipients lacked the resources to pay for such charges and so would be denied access to basic health care by their imposition.

H.R. 7029, which would authorize copayments for categorical assistance recipients for mandatory Medicaid services, would undermine the fundamental purpose of the Medicaid Act. It will deny the most crucial medically necessary health care to many needy individuals, and cause untold physical and emotional suffering. Offered as a device for curtailing unnecessary utilization, it does not distinguish between medically necessary health care and unneeded care as the many legitimate utilization controls available to the states can. The clear weight of experience and professional authority has shown co-payments to be a cost-ineffective device which not only denies medically necessary care, but results in an increased need for and use of much higher cost care, while failing to target the causes of improper utilization. Meanwhile their impact on recipients can be devastating.

---

*This exemption has been specifically articulated in the statute, 42 U.S.C. 1396a(a)(14)(A)(i), since 1972, but was acknowledged as fact from the inception of the program, under that provision's former language. See former H.E.W. "Handbook of Public Assistance Administration" Supp. D, §5430.1.

Impact on Categorical Assistance Recipients

> "For the elderly poor, a 50-cent copayment, which seems insignificant to most of us, can mean the difference between a needed prescription and a quart of milk or a loaf of bread. What right have we to ask them to make this choice? There are people living in or approximate to my District who have to make a choice every day between a cup of coffee and the morning newspaper."
>
> ---Hon. Claude Pepper

Categorical assistance recipients can not afford copayments. It is undisputed that their assistance grants do not allow for them. On the contrary, categorical assistance "standards of need" cover only the minimal, bare essentials of life---food, shelter, and personal maintenance needs**---and no more. As the Senate Finance Committee, referring to Medicaid copayments, noted as early as 1968, "cash assistance recipients ...have been determined to have no income or resources available to meet such charges." Sen. Rpt. No. 744, 88th Cong., 2d Sess. (1968); 1967 U.S. Cong. Code & Admin News 2834, 3024.***

Categorical Assistance recipients will have to fund their copayments from amounts deemed minimally necessary for food, clothing and rent. Unfortunately, those amounts are themselves typically inadequate to provide for even the basic necessities of life.

---

*House Select Committee on Aging, Comm. Pub. No. 96-181 (1979), p. 28.

**Some states also provide for qualified recipients' "special needs" also, but these are specifically defined and don't relate to medical costs.

***See also the former H.E.W. "Handbook of Public Assistance Administration," Supp. D §5430.1 (1967), which provided in part:

> "For the categorically needy person, no such deductible or cost sharing is permitted, since there is no income beyond that required for maintenance."

Few "standards of need" have kept pace with the actual costs of the meager needs they theoretically cover. Moreover states have not been required to update their AFDC "standards of need" since 1969, and many are seriously outdated; and states are able to---and several do---pay categorically assistance recipients less than 100% of their own need standards. Alabama, for example, has an AFDC need standard of $240 per month for a family of 4, but pays only 61.5% of that, or $148. Illinois, for example, provides $350 per month for a family of 4. While some states pay more, others pay less; none purport to provide for more than the bare minimums noted. Forcing people to further deplete that life-sustaining income to fund needed health care is unconscionable.

Cash assistance grants under SSI, the categorical assistance program for the needy elderly, blind and disabled, are $238 per month ($357 for a couple) as of July 1.* SSI does not purport to cover health care costs and, as noted earlier, its recipients are accordingly automatically exempted from copayments under 42 U.S.C. 1396a(a)(14)(A)(i). While all recipients would suffer from the copayment burden, a burden which, parenthetically, is compounded for families based on the cumulative copayments of family members, the elderly and disabled poor will be particularly hard hit. They tend to have a higher incidence of medical needs, and so will face a greater number of agnoizing choices and a greater likelihood of

---

*SSI replaced three previously-existing categorical programs which, like AFDC, had state-established standards of need, in 1974. Many states had to supplement SSI payments simply to keep grants as high as their pre-SSI assistance grants. They were not required to update those payments, although some states do. On the other hand, 14 states have exercised the option provided by 42 U.S.C. 1396a(f) to use Medicaid eligibility standards for the elderly, blind and disabled that are lower than SSI standards (referred to as the "209(b)" option).

best copy available

denial of needed care. In addition Medicaid nursing home residents, who are primarily elderly and disabled, retain only a small "personal needs allowance" for personal income. It does not have to be more than $25/month, and is not designed to cover medical expenses.** The effect of copayments on these people will be particularly devastating.

In recognition of this certain harm, the Medicaid program has always excepted categorical assistance recipients from copayments on the mandatory services. California, which imposed copayments on physician services (and prescription drugs) in a H.E.W.-approved experimental project in 1979-73, abandoned all copayments when the experiment ended. The California experiment and its results are discussed by Dr. Roemer in his statement and materials annexed hereto.

It is hard for persons with adequate incomes to understand what copayments on medical care for the very poor will mean. After all, most middle and upper income Americans would not delay going to a doctor or having a prescription filled because of a 50 cents or $1 copayment. But for the poor, a copayment does just that--it causes them to delay or avoid entirely the seeking of medical care when ill, or forces them to do without other necessities of life. The following examples are illustrative of the harsh effects of the copayments envisioned by H.R. 7029:

**See, e.g., 42 C.F.R. 435.725; Medical Assistance Manual §4-40-30(A)(1). For a couple this amount must be $50/month. States may provide higher amounts, based on a determination that the covered needs require it, and some states do.

---A San Francisco woman we represented at the time of the California copayment experiment* had been recently hospitalized with malnutrition. In addition, she had a chest condition and had lost one lung, and suffered emotional problems requiring psychiatric care. Her small V.A. benefit was supplemented by categorical assistance up to the cash maximum, and she received Medicaid. She could not afford to meet her necessary living expenses, including her desperate need for improved food, and still pay the [$1] copayment for each of several physician visits she truly needed. She lived in dread of emergencies, unable to meet the copayments.---

---A poor couple in San Antonio recently sought admission to a clinic for the wife's complaints of coughing and congestion. Unable to pay the facility's $3 charge (the husband had only $.18 in his pocket), they were turned away. Two days later the wife died of double pneumonia.---

---A 41-year old man we represented suffered from Parkinson's disease and required medical services at least twice a month and several prescriptions. Out of his $312.50/month (in 1972) income he supported his wife, daughter and household. He could not afford to pay for dental work he and his daughter needed, his car and household appliances were in need of repair, and he could not afford to pay all the copayments on the services he needed.---

---We represent a disabled Florida man whose sole source of income is SSI. He suffers from chronic anemia, pancreatitis, cirrosis of the liver, lumbar discongenic disease, tuberculosis, and mulnutrition, for which he requires approximately 3-6 physician visits per month. In some months when then-existing

---

*NHeLP was co-counsel for plaintiffs in California Welfare Rights Organization v. Richardson, 348 F. Supp. 491 (N.D. Cal. 1972), which unsuccessfully sought to challenge H.E.W.'s decision to authorize the experiment. Because the experiment permitted copayments on a "mandatory" service (physicians services) in contravention of 42 U.S.C. 1396a(a)(14)(A)(i), it required H.E.W. approval as a "Demonstration Project" pursuant to 42 U.S.C. 1315. We were also co-counsel in Crane v. Matthews, 417 F. Supp. 532 (N.D. Ga. 1976), in which a similar experimental project in Georgia was enjoined on account of the state's and H.E.W.'s failure to follow procedures designed to protect "human subjects" of an experiment. To our knowledge then, the California experiment stands as the only example of the consequences of an enactment like H.R. 7029.

Florida Medicaid regulations** prevented him from obtaining all the ambulatory care he needed, he had to be hospitalized.---

Assessments of Co-Payment Schemes

Proponents of copayments offer them as a means for curtailing unnecessary health care utilization and, as a result, containing medical care costs. There are, however, no studies which support these contentions. To the contrary, studies on the effect of copayments on the poor and near poor show that they: (1) cause a reduction in needed medical care; and (2) ultimately increase the costs of medical care because of delays in early treatment and diagnosis. There is also reason to believe that the imposition of copayments leads to a reduction in the number of providers willing to accept Medicaid patients.

Medicaid copayments on mandatory services may indeed bring about a short-term reduction in expenditures, but not because they will ferret out unnecessary utilization. They simply prevent large numbers of needy people from seeking all the care they need. And in the long-run, apart from the pain and suffering they cause, they result in increases in more expensive forms of care such as hospitalization. The classic study of the effects of copayments ---which focused on the 1972-73 California experiment with Medicaid copayments on physician visits and drugs---was conducted by Dr. Milton I. Roemer and his associates and reported in an article

---

**Florida did not, of course, have co-payments on physician visits; rather they limited visits to three per month. However this client illustrates the range of health care needs many individuals have, the magnitude of co-payments they would have to face, and some consequences of their being unable to get needed care.

entitled, "Copayments for Ambulatory Care: Penny-Wise and Pound Foolish," 13 Medical Care 457 (June 1975). We are submitting with this testimony a copy of that article, as well as a current statement on point prepared by Dr. Roemer for purposes of this hearing, and ask that they be made a part of this record.

Observing that copayments impact with particular severity on the poor, the study observed that their inhibiting effect on access to care operates irrespective of the need for care. Due to the circumstances of the California experiment, Dr. Roemer was able to compare recipients who had to pay copayments with those who did not, and examine their health care patterns both before and after the imposition of copayments. As noted in the annexed material, the study demonstrated that, while ambulatory care utilization was less for the copayment group, their hospitalization rates (and their attendant higher costs) increased dramatically, observing:

> "It is likely that this elevated hospitalization rate is due to the postponement of ambulatory care, so that when a patient is finally driven to seek assistance, his case is more advanced..." (emphasis added)

The study concluded that the copayment experiment cost California an additional $1,228,150. The conclusions of the Roemer study have been supported by scholarly research since. As Dr. Roemer's statement notes, for example, the Rand Corporation confirmed his findings and conclusions in a 1978 study done for H.E.W.*

---

*L. Helms, J. Newhouse & C. Phelps, "Copayments and Demand for Medical Care: The California Medicaid Experience" (Rand, 2/78). It should be noted that, since the California experiment imposed copayments only on recipients with some resources, the impact of unrestricted copayments would be even more harsh and cost-ineffective.

And, for example, a 1979 study of restrictions on access to drugs in Louisiana's Medicaid program showed that while drug expenditures decreased by $4.1 million, program expenditures increased by $15.1 million due to increased hospitalization for Medicaid recipients. Diseases identified as being most affected by the restrictions were found to have been significantly affected.*

It is a well-known fact about our health care system that physicians, not patients, determine the amount and kind of medical services provided. In terms of utilization, recipients have little power over the expenditure of health care costs. They can not diagnose, prescribe treatment or medications, or grant themselves an unnecessary hospital admission; it is the providers who do that. Indeed, physicians alone direct or control more than 70% of all health care expenditures, see "Doctors Play Key Role in Determining How High Health Costs Climb," Nat'l Health Insurance Report, Vol. 9, No. 24, Capital Publications (Wash. 11/16/78). This is why legitimate utilization control devices focus on the nature of care sought, rather than, as copayments do, an individual's attempt to seek care.

If there is overutilization of the Medicaid program, then it is caused by providers, not recipients. To make the poor pay for this overutilization by instituting copayments is economically short-sighted, and medically foolish. It is also cruel and inhumane.

---

*D. Hefner, "A Study to Determine the Cost Effectiveness of a Restrictive Formulary: The Louisiana Experience" (1979). The restrictions involved the removal of some drugs from Medicaid coverage. The study's results can fairly be said to reflect the consequences of the restricted access to care that copayments cause.

H.R. 7030

The Medicaid Act presently makes it a criminal offense to, among other things, knowingly and willfully make false statements of material facts in applications, or for use in determining rights to benefits, 42 U.S.C. 1396h(a). That section further provides that when an individual is convicted of such an offense, the State may restrict or suspend the individual's Medicaid eligibility for up to a year. H.R. 7030 would amend the section to also allow the same sanctions to be imposed after a finding, presumably in an administrative proceeding, that an individual had committed any act described in the criminal offenses. H.R. 7030 furthermore provides that the standard of proof in such an administrative proceeding will be "preponderance of the evidence."

In our judgment the proposed amendments represent an unwarranted and dangerous extension of the States' powers to adjudicate alleged misconduct and suspend access to health care, in a sensitive area where the standards of proof and protections of a criminal proceeding properly apply. Questions of Medicaid eligibility are frequently found to be difficult and confusing by agency staff and applicants/recipients alike. To deny individuals protections such as proof "beyond a reasonable doubt" when they are accesed of "knowingly and willfully" making (or causing to be made) false statements and "representations" will lead to untold numbers of innocent people being unfairly punished with an extremely severe sanction---the loss of health care for up to a year. Moreover, given the frequently-evidenced tendency of state agency personnel to interpret eligibility provisions almost presumptively against

applicants/recipients, and the procedural inadequacies frequently found in state "Fair Hearing" procedures,* the need for the proof standards and protections associated with criminal proceedings is all the more apparent.

Medicaid eligibility is determined under a large array of regulations and policies, the correct interpretation of which is frequently unclear. WHeLP constantly receives requests for advice from professional legal workers seeking clarifications as to the meaning of particular eligibility rules. Indeed, one federal judge has noted that the Medicaid regulations have a complexity "which make them almost unintelligible to the uninitiated,"** and another judge once referred to them as a "Sibernion bog."*** The considerable potential for honest error or misunderstanding by recipients ---over 30% of whom, nationwide, have less than an 8th grade education****---is furthermore illustrated by the large numbers of errors that state agency staff make in eligibility determinations. For example, a 1979 study done for H.E.W. estimated that there were about 268,000 erroneous denials of benefits to AFDC Cases in a six-month period in 1977***** Parenthetically, recipients appealed

---

*See, e.g., Featherston v. Stanton, U.S. Ct. App., Seventh Circuit, 1980, CCH Medicare & Medicaid Guide ND ¶30,591; Arelzaga v. Quern, 590 F.2d 226 (7th Cir. 1978); Smith v. Trainor, U.S. Dist. Ct., N.D. Ill. 1979, CCH Medicare & Medicaid Guide ND ¶30,435; Parent v. Minter, 362 F. Supp. 85 (D. Mass. 1973).

**Judge Friendly in Friedman v. Berger, 547 F. 2d 724, 727 (2d Cir. 1976).

***Feld v. Berger, 424 F. Supp. 1356, 1357 (S.D.N.Y. 1976).

****U.S. Census Bureau, 1976 Survey of Income and Education.

*****H. Richardson, "Due Process in Monthly Reporting & Retrospective Budgeting," H.E.W., Office of Asst. Secretary for Planning & Evaluation (5/29/79).

only 5% of these. Another study done for H.E.W. showed that only 5% of the recipients eligible for one form of Medicaid eligibility in Massachusetts obtained benefits and that between 22% and 73% of them (depending on locale) reported lack of understanding of the eligibility procedures as the reason.*

Given these circumstances, and the nature of the threatened sanction involved, it is obvious that a substantial proof standard should be used to confirm that recipient errors in an application are knowingly and willfully fraudulent. The Medicaid Act has, since its inception, required the proof "beyond a reasonable doubt" standard incorporated in criminal proceedings to be the test of such alleged fraud, 42 U.S.C. 1307, 42 U.S.C. 1396h (1972). H.R. 7030 proposes to reduce that standard to a "preponderance of the evidence," which means that a state will be able to adjudicate culpability whenever it determines that the evidence favors its view more than the recipient's. While this seems inherently wrong on its face, it is particularly unconscionable in light of the penchant for harsh and arbitrary decision-making states have often demonstrated.

The arbitrary ways in which states have ruled on eligibility questions illustrate the dangers embodied in H.R. 7030. Cases involving the application or transfer of assets rules provide important examples of the kinds of decisions state agencies can reach when permitted to judge their assessment of eligibility facts to be more convincing than a recipient's. Transfer of assets rules

---

*Urban Systems Research & Engineering, Inc., Evaluation of the Medicaid Spend-down (1976). The study focused on "medically needy" eligibility.

allow a state to disqualify a person for Medicaid benefits if it finds that an applicant or recipient has (within a specified number of years before applying) transferred property for less than reasonable value, or for purposes of qualifying for Medicaid. Without questioning the validity of such rules, we note that in at least 6 states Federal courts have found that state Medicaid agencies were effectively presuming guilt under transfer of assets rules despite recipients' presentation of substantial evidence to the contrary.*

As examples of such arbitrariness we note the following: In one case, a New York man had transferred property to his mother to pay a debt. Two years later he was shot in the head and sought Medicaid assistance; the state agency ruled he had transferred the perperty in order to qualify for Medicaid. In another example, an 80-year-old invalid had transferred his half interest in his home to his daughter. He did so in return for her having moved from Florida to Connecticut to care for him and her having paid for the maintenance of the house for ten years. Nonetheless the state ruled he had not transferred for "fair value," and so was disqualified for Medicaid. Other examples of such arbitrary disqualification decisions involved, e.g., when applicants had transferred assets on the advice of social workers; where elderly applicants' properties had been transferred from them without their knowledge; and where elderly applicants had made transfers permissible under one program (SSI) only later to be told they had done it unlawfully to secure Medicaid.

---

*See, e.g., Buckner v. Maher, 424 F. Supp. 366 (D. Conn. 1976), aff'd 434 U.S. 898; Owens v. Roberts, 377 F. Supp. 45 (M.D. Fla. 1974).

We consistently see similarly arbitrary results under other types of eligibility determinations. For example, a 65-year-old Virginia woman, partially blind and deaf and suffering a nerve condition, shared ownership in a parcel of land with 27 relatives scattered about the country. The percentage of the tax-assessed value of the property reflected by her percentage ownership share exceeded the resource limit for Medicaid eligibility and the client was found ineligible---even though federal law requires that the resource be "available" to the applicant. Virginia apparently uses the tax-assessed value of properties in applying its resource eligibility limits, even where market value is much less. Only last fall, a federal court enjoined North Carolina's practice of looking at only the tax-assessed value of property---and refusing to consider proof of actual value---in eligibility determinations.* Under N.R. 7030, had the elderly woman failed to list the mathematical value of her interest in the property as an available resource, or if applicants in North Carolina listed the market value of their property rather than the tax-assessment figure, they would face the clear prospect of a fraud charge.

As the above-noted examples suggest, applicants and recipients are frequently shocked to learn that income and resources they did not realize they had available to them are considered available by the state agency. The most familiar example is the commonly-observed practice of states' "deeming" of contributions from one relative to another regardless of proof of actual receipt. Other examples of non-existent income and resources states have ruled

---

*Simmons v. Morrow, C.A. No. 79-?9-Civ-7 (E.D. N.C. 9/25/79).

as available to recipients include F.I.C.A. tax deductions, the value of shelter provided by others, and a spouse's social security benefits. These recipients might well not report such income as available to them and, under H.R. 7030, be liable to a "fraud" conviction and a year's Medicaid disqualification.

While the dangers to recipients would be great were states to utilize this proposed remedy, curiously enough there is some reason to conclude that creation of the remedy might be generally a redundancy. H.R. 7030 does not create new offenses; it merely permits states to initiate administrative proceedings (albeit with a lower proof burden) based upon evidence which can presently be forwarded for judicial proceedings. Recent experiences with analogous provisions in the Food Stamp Program cast some doubt on whether provisions like this will be much used.

The Food Stamp Act, 7 U.S.C. 2015(b), authorizes both administrative and court proceedings to adjudicate charges of fraudulent obtaining of benefits. An individual so adjudicated is disqualified for three months after an administrative finding, and for at least six months after a judicial finding. By implementing regulation, the Dept. of Agriculture has provided that the burden of proof on the state agency at administrative proceedings is "clear and convincing" proof of willfully and deceitfully intentional fraud, 7 C.F.R. 273.16(d)(6). Experience has shown that the states rarely utilize the administrative proceeding; in fact, the House Agriculture Committee recently reported that states were failing to conduct such proceedings even when the Department had advised

them it was a mandatory responsibility.*

The Committee noted the view of "many states" that the expense of administrative proceedings was wasteful, particularly when the same evidence is referred for judicial action, and that the civil proceedings might even jeopardize the accused's constitutional safeguards. States apparently question whether they have an adequate amount of trained staff to meaningfully pursue the administrative remedy. The federal government has found it necessary to offer the states financial inducements---such as a higher administrative reimbursement rate and a share of recovered funds ---to conduct such hearings, without measurable result. While it can only be conjecture, it is reasonable to assume that the states' behavior regarding the administrative option provided by H.R. 7030 will be similar to that experienced under the Food Stamp program.

It seems that if states were to opt for the administrative proceeding proposed by H.R. 7030, it would be primarily because it would make "proof" of fraud much easier.** Of course, it does so only by creating a new and unprecedented offense---fraud based upon agency surmise. If there are any other legitimate reasons for proposing the administrative option---such as avoiding court-calendar congestion and/or using judges more familiar with the Medicaid system---such a remedy should be crafted in a way which does not threaten recipients' legitimate interests. Such a proposal might direct an administrative hearing with the protections ---including the "beyond a reasonable doubt" proof standard--- that criminal proceedings use. That, H.R. 7030 most decidedly does not do; we urge most emphatically that it not be enacted.

Respectfully submitted,

Michael C. Parks, Staff Attorney
Geraldine R. Dallek, Health Policy Analyst
NATIONAL HEALTH LAW PROGRAM, INC.
Los Angeles, California Sept. 8, 1980

---

* Report on S. 1309, Food Stamp Act Amendments of 1980, Report No. 96-788 (2/27/80), pp. 114-115. The Report notes that the department's mandatory rule did not in fact comport with the legislative intent; it was subsequently amended.

** We note that Alabama recently passed a law (P.L. 85, 3/18/80) under which a Medicaid recipient would be disqualified from Medicaid for at least a year whenever a utilization review committee of the state agency determines the recipient "abused" or "misused" program benefits. No appeal process is provided.

UNIVERSITY OF CALIFORNIA, LOS ANGELES

BERKELEY · DAVIS · IRVINE · LOS ANGELES · RIVERSIDE · SAN DIEGO · SAN FRANCISCO — SANTA BARBARA · SANTA CRUZ

22 July 1980

SCHOOL OF PUBLIC HEALTH
LOS ANGELES, CALIFORNIA 90024

Michael C. Parks, Esq.
Staff Attorney
National Health Law Program
2639 South La Cienega Boulevard
Los Angeles, CA 90034

Dear Mr. Parks:

It was distressing to learn from you about the proposal in the current U.S. Congress of H.R.7029, which would amend Social Security Act Title XIX, to permit State Medicaid programs to require "nominal co-payments for basic services provided to categorically needy individuals."

As you know, California was authorized by the Federal Government to conduct an "experiment" on precisely this issue in January 1972--that is, to learn what would happen if Medicaid enrollees were required to co-pay a nominal charge of $1 for each of the first two visits to a doctor and 50 cents for each of the first two drug prescriptions in any month. After the experiment was started, colleagues and I at the University of California (UCLA) were asked by the Department of Health, Education, and Welfare to evaluate the results, and were given a special grant to enable us to carry out this study.

Our findings on the outcome of this Medicaid co-payment experiment were so negative that one would have thought that the idea would never be raised again. These findings were reported in a professional journal, Medical Care, in June 1975, and I enclose with this letter three reprints of the article.

To assess the effect of the apparently small co-payments imposed, we collected data from the State Medicaid program for a period six months before and 12 months after the experiment started. I should explain that the State decided to impose the co-payment requirement only on Medicaid beneficiaries who had some additional financial resources beyond their cash benefits, using the other even poorer clients as a "control" or comparison group. Since these two populations were rather different to start with, having very different prior rates of medical care utilization, we had to use an "indexing" technique to make scientifically reliable comparisons.

I should also explain that in October 1971, three months before the co-payment was started, the California State government had introduced another measure to control utilization of Medicaid services--a requirement

of "prior authorization" from a State Medicaid consultant for any ambulatory services of a doctor beyond two in a month, and likewise for more than two prescriptions in any month. The effect of this requirement, which was applied across-the-board on both the "co-pay" and "no-pay" groups, depressed the utilization rates of both these populations even before the co-payments began.

As you will find in the enclosed article, however, after the co-payment levy began, the relative utilization rate of those indigent people who had to co-pay declined even further than that in the comparison group which was not required to make co-payments. This steeper decline in medical care use applied to doctor's office visits, laboratory tests (as reflected in urinalyses), drug prescriptions, and most markedly to preventive services (as reflected in Pap smear tests).

Co-payments were not imposed for hospitalization, since this is always the doctor's decision. Our crucial finding concerned the trend of this most costly component of medical care. After a brief lag, as shown in Figure 5, and more dramatically in Figure 6 of the article, the relative rate of hospitalization of the "co-pay" population rose to higher levels than that of the "no-pay" population.

From these overall findings we were forced to conclude that even a nominal co-payment requirement on poor people effectively reduces their access to primary medical care--that is, attention in the doctor's office or clinic when an illness starts. After a short while, however, society pays a price for this postponement of care. When symptons finally drive the patient to seek medical assistance, his sickness has evidently advanced to a stage at which hospitalization becomes necessary--to an extent relatively greater than for those people who were not deterred by co-payments from seeking needed medical care promptly.

We calculated the financial impact of these dynamics and found, in a nutshell, that while the State Medicaid program saved a little money ($88 per 1,000 enrollees per year) from the reduced use of ambulatory care, it lost much more ($935 per 1,000 per year) from the excessive use of hospitalization. This is why we entitled our paper reporting the results of this experiment: "Co-payments for Ambulatory Care: Penny-wise and Pound-foolish." The ultimate effects on the health of these poor people, we could not measure, but I suspect they were probably equally negative.

In reporting these findings about the futility of co-payments in a poverty population, I am not unaware of the serious problems of rising Medicaid costs, faced by both State and Federal governments. Deterrents on the initial procurement of medical care, however, are simply not the way to save money. There are other reasonable ways--such as prior authorization being required for non-urgent hospitalization, particularly

elective surgery. This places an obligation on the doctor to justify the need for costly hospital procedures. It can not only save much more money than deterring primary care, but can spare patients from so much of the elective surgery which has been shown in the Medicaid program to be questionable or unnecessary.

Strategies applying peer review--of which prior authorization for elective procedures is one type--are not only protective of the patient, but also can more effectively prevent financial waste. This administrative safeguard, as you know, is already permitted in the Medicaid program.

I should explain also that our statistical findings in this research were challenged by one observer, on the basis of the indexing methodology used. To settle the issue, the State data tapes were sent to the RAND Corporation for independent analysis. Using a different analytic technique, the RAND scientists confirmed our original findings at UCLA.

The issue of co-payments and other forms of cost-sharing has long been debated in medical care programs. In populations of moderate or high income they can sometimes save program money, just by the amount of money co-paid, even though there is little effect on utilization rates. In poverty groups, however, their effect is to inhibit medical services, which are typically underutilized anyway, in relation to needs. This is why so many other countries with national health programs, such as Sweden, may require co-payments for primary care from the average person, but waive them for the poor.

To permit co-payments on the patient, for diagnostic tests and hospitalization ordered by the doctor--as I gather would be authorized in H.R.7029--seems even more inappropriate. Not only would this place an unfair and unreasonable burden on the patient, but it could also constrain the doctor from doing what is necessary for proper patient care.

I fully share your hope, Mr. Parks, that the Congress will do nothing that might lead other states to apply the technique that California found to be counter-productive in its Medicaid program some time ago. Nothing has occurred in the intervening years to alter our conclusion that cost-sharing requirements in programs of medical care for the poor are unsound from both a fiscal and a human point of view.

Sincerely yours,

Milton I. Roemer

Milton I. Roemer, M.D.
Professor of Health Services

MIR:m74
Enclosure

68-669 O—80——8

Reprinted from MEDICAL CARE, Vol. 13, No. 6, June, 1975
Copyright © 1975 by J. B. Lippincott Company Printed in U. S. A.

Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish

MILTON I. ROEMER, M.D., CARL E. HOPKINS, PH.D., LOCKWOOD CARR, B.S., AND FOLINE GARTSIDE, M.A.

The California "copayment experiment" imposed a charge of $1 on certain Medicaid beneficiaries for the first two visits to a doctor and 50 cents for the first two drug prescriptions each month, effective January 1, 1972. Data on utilization rates were gathered for six months before this date and for 12 months after it. While other administrative requirements, like prior authorization of certain services, doubtless also played a part, it was found that, following the start of copayment, utilization of ambulatory doctor's office visits and other services associated with them showed a decline, relative to that of the non-copayment cohort. After a brief lag, however, hospitalization rates in the copay cohort rose to levels higher than those of the non-copayment cohort—more than offsetting the savings to the state from the reduction of ambulatory service use rates. Due presumably to the neglect of early medical care because of the inhibiting effect of the copayments, these higher use rates of costly hospitalizations suggest that financial deterrents on access to ambulatory service by poor people are penny-wise and pound-foolish, not to mention their effects on health and well-being.

Note: The following paper was prepared and submitted before the publication of "California's Medi-Cal Copayment Experiment" by Earl W. Brian and Stephen F. Gibbens as a special Supplement to the December 1974 issue of this journal. Although examining the same medical care program, our study is based on a cohort analysis over time—before and after the imposition of copayment requirements—and applies statistical techniques which adjust for the critical differences in "test" and "control" populations, not done in the previous report. Moreover, it examines hospitalization experience not only because of its costliness but especially because of its value as a reflection of the long-term effects of the demonstrated reduction in ambulatory services. As a result, our conclusions on the ultimate consequences of copayment fees for ambulatory services in a low-income population are very different from those of Brian and Gibbens.

ONE OF THE persistent subjects of debate in planning health insurance or other financial support programs for medical care is the effect of copayment or deductible requirements. Applied in many programs, both private and governmental, the general assumption has been that these cost-sharing charges would inhibit "unnecessary" or "frivolous" demands for medical care, and therefore reduce the burden on the fiscal source and available health manpower.[2]

Copayment as a Deterrent to Use of Medical Care

Much research has been done on the question of copayment as deterrent, with conflicting findings. Obviously the effects of cost-sharing on utilization or demand depend on the amount of money involved—either in fixed dollars or percentage of charges, on the income level of the insured, on whether the copayment applies to a service ordered by the doctor (like hospitalization) or to one initiated by the patient (like an ambulatory visit), and on other factors. The weight of evidence seems to

From the University of California, Los Angeles School of Public Health.

Support for the research reported in this paper was given by the U.S. Social and Rehabilitation Service (SRS Project Grant 18-P-50006/9).

suggest that for services decided upon by the doctor, if the cost-sharing requirement is small, the effects are transitory or virtually nil.[5] For patient-initiated services, on the other hand, the inhibiting effect of copayments on utilization may be substantial, but especially so for lower income families.[1]

A depressing effect of copayments on consumer demand obviously reduces medical care expenditures in the short run, even if one counts both personal outlays and payments from a social (insurance or revenue-derived) fund. For the social fund, moreover, the saving results from two mechanisms: 1) the reduction in numbers of medical claims, and 2) the nonpayment by the fund of the copayment amount itself. These fiscal effects, however, tell us nothing about the medical or health consequences of the copayments. It certainly cannot be inferred that a patient's failure to see or delay in seeing a doctor for a symptom means that the ambulatory visit was unnecessary or frivolous. It means only that the copayment obligation effectively inhibited the procurement of care, whether it was medically advisable or not. A recent review paper by researchers from the Rand Corporation, for example, draws the conclusion that copayments reduce ambulatory care demand, thereby saving health insurance funds; it does not consider, however, the possible effects on health.[6] Nor does it consider the later demands for care that these health effects might generate, perhaps more than offsetting any initial savings.

An investigation of the so-called "California Copayment Experiment" (hereafter called COPE) which operated under the Medicaid program from January 1972 until July 1973 provided us with an opportunity to probe this question—that is, the longer term effects on health and costs of a small copayment obligation imposed on Medicaid beneficiaries as a condition for visiting a doctor and for having a prescription filled. Examining the experience of the California COPE program before its start and for 12 months after permitted some inferences on both these matters.

The California "Experiment" and Its Assessment

In brief, the California State Department of Health Care Services imposed a copayment charge of $1 on certain Medicaid beneficiaries for the first two visits to a doctor each month after January 1, 1972. The doctor or his assistant was expected to collect the dollar and, whether he did or not, the State deducted one dollar from the fee payable under the program. Similarly, a 50 cent copayment was imposed for the first two drug prescriptions each month, this amount to be collected by the pharmacist. A survey of providers showed that over 80 per cent of the doctors and 90 per cent of the pharmacists did, in fact, collect the COPE charges.

Under the original Medicaid law (which barred states from imposing any payment obligations on the indigent beneficiary for statutorily required medical services), this California measure could be approved by the federal Department of Health, Education, and Welfare, only if it was considered an "experiment." Our research group at UCLA, which was called upon by the federal Department to evaluate the results, was not involved in the experimental design. Had we been, we would have much preferred to establish two randomly chosen or matched populations of Medicaid beneficiaries, one of which was required to copay while the other was not. Instead, the State—perhaps in the interests of compassion—decided to impose the copayment obligation only on those Medicaid beneficiaries who had some additional financial resources outside their statutory cash benefits, while not imposing it on the rest of the eligible persons.

Thus the two populations, with respect to "copay" or "no-pay" status, were not

basically alike. The copay group, constituting families with some resources, tended to be a decidely older-age population. Even though our evaluative study was confined to AFDC (Aid to Families with Dependent Children) beneficiaries, the children in the copay families tended to be older. Moreover, the very existence of some extra resources in these families meant that their standard of living and perhaps other cultural characteristics were likely to differ from those in the more impoverished no-pay AFDC population. These differing sociodemographic characteristics would inevitably influence tendencies to seek medical care and meant, unfortunately, that our evaluative research could not be based on a simple comparison of the trend lines of the medical care demand rates of the two populations.

Instead, it was necessary to establish two cohorts of copay and no-pay populations, to follow their demand rates for a reasonable length of time both *before* and *after* the imposition of the copayment charge, and then to compare not the absolute rates but the *relative* levels of utilization of various types of medical care by the two populations. This could be achieved by establishing a base period, prior to copayment, at which the actual utilization rates of the two populations were converted to a common *index* figure of 100. Then one could follow the trend lines for the indices of the two cohorts to determine whether, after the imposition of copayment in one cohort, a difference was observable in the demand or utilization trends followed by each.

Since California is a large state, and our research funds were limited, we could not examine the total experience of the State's over 2,000,000 Medicaid beneficiaries. We chose instead the AFDC universe within three counties (San Francisco, Tulare, and Ventura) believed to be fairly representative of the State as a whole, both in urban-rural distribution and in ethnic or racial composition of Medicaid persons.* In these three counties, the copay cohort population throughout the observations numbered 10,687 and the no-pay cohort numbered 29,975, or a ratio of roughly 1:3. This ratio was also characteristic of the Medicaid population in the State as a whole.

TABLE 1. Service Data Collection Quarters

Quarter	Time-Period	Status
1	July-September 1971	Before copayment
2	October-December 1971	Before copayment
3	January-March 1972	Copayment started (Jan. 1)
4	April-June 1972	Copayment in effect
5	July-September 1972	Copayment in effect
6	October-December 1972	Copayment in effect

To establish the basis for these two trend lines, as noted above, a time span was studied beginning six months before the copayment charge was imposed and ending 12 months after. Computerized data were examined for medical and related claims paid for services actually rendered during six quarterly (three-month) periods over this 18-month span. The exact quarters for which service data (from paid claims data tapes) were collected are shown in Table 1.

Findings

In Table 2 are presented the actual rates of doctor's office visits per 100 eligible AFDC Medicaid beneficiaries over the 18-month study period. Also presented in this table are the same rates, adjusted to an index figure of 100 for the first quarter, as

* Originally, information had been obtained on seven counties, but examination showed so many serious gaps and problems in the claims and eligibility data in four of the counties that we felt compelled to reduce the sample to three counties; in these, the data were satisfactory for analysis.

TABLE 2. Doctor's Office Visit Rates for AFDC Families, by Copayment Status in California Medicaid Program, July 1971-December 1972: Number per 100 Eligibles per Quarter-Year, and indices of Rates Based on Quarter 1 = 100

Quarter	Doctor's Office Visits per 100 Eligibles		Index of Office Visit Rates (Quarter 1 = 100)	
	No-pay	Copay	No-pay	Copay
1	79.54	75.47	100	100
2	66.79	59.96	84	79
Copayment Started				
3	79.09	69.13	99	92
4	71.24	64.77	90	86
5	67.46	59.55	85	79
6	73.18	66.31	92	88

Note: Illustrated graphically in Figure 1.

explained above. Graphic presentation of the index figures from Table 2 appear in Figure 1.

Interpretation of this table (and subsequent tables and figures) requires further explanation about the course of events in California's Medicaid program over this 18-month period. In October 1971, at the start of Quarter 2, a number of administrative changes were introduced in the program; most important among these was a requirement of prior authorization from a State

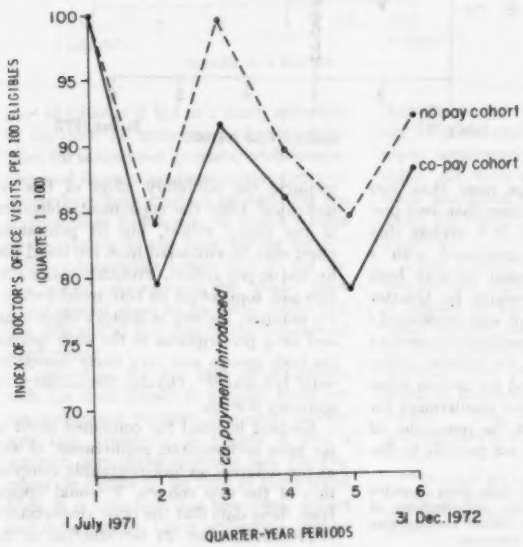

FIG. 1. Doctor's office visit rates for AFDC families, by copayment status in California Medicaid program, July 1971-December 1972; indices of rates based on Qnarter 1 = 100.

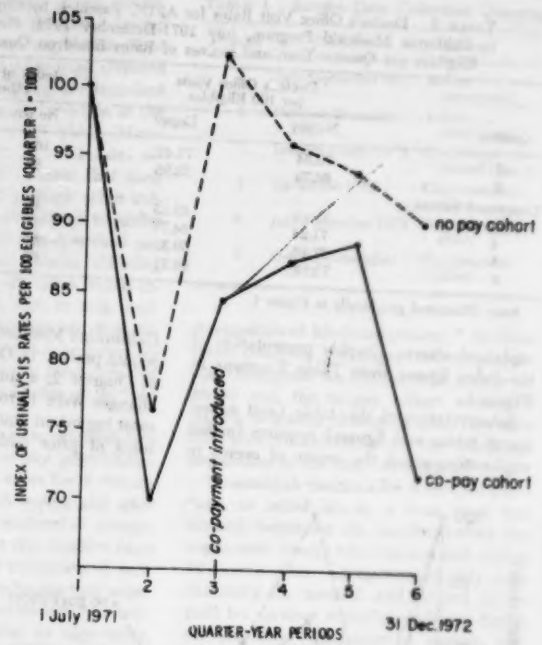

FIG. 2. Urinalysis rates for AFDC families, by copayment status in California Medicaid program, July 1971 – December 1972; indices of rates based on Quarter 1 = 100.

Medicaid Consultant for more than two ambulatory services or more than two prescriptions in any month. It is evident that this requirement was associated with a sharp decline in utilization rates of *both* the no-pay and copay cohorts for Quarter 2, even before copayment was introduced.[3] Prior authorization for ambulatory services beyond two per month, for nonemergency hospital admissions,† and for certain other services was a continuous requirement for both cohorts throughout the remainder of these observations. It is not possible to disentangle the inhibitory effect of this requirement from the copayment obligation in the copay cohort, but its substantial effect may be estimated from the trend line for the no-pay cohort. Probably seasonality also had some effect on both trend curves—for example, the rise in doctor's office visits and drug prescriptions in the sixth quarter for both groups was very likely associated with fall-winter (October-December) respiratory disease.

Keeping in mind the combined effect of the prior authorization requirement, as well as the different sociodemographic composition of the two cohorts, it would appear from these data that the prior authorization requirement, after its introduction at the

† This restriction had, in fact, been operative since April 1968. Such prior authorizations, of course, have been used to restrict medical care use in welfare program for centuries.

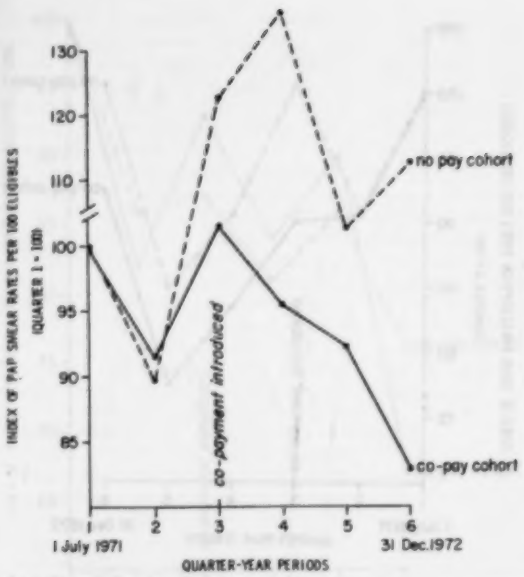

FIG. 3. Pap smear rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

start of Quarter 2, led to a sharp reduction in the rate of ambulatory doctor visits. Then for subsequent quarters, while seasonality and disease incidence associated with it may have been exerting an influence, the copay cohort had a rate of doctor's office visits—relative to the base period for the index—substantially below that of the no-pay cohort throughout the study span. There would seem to be little doubt that this differential was due to the copayment requirement.

Continuing, for the sake of simplicity, with the data simply in graphic form, we can consider a common diagnostic laboratory test, urinalysis, in Figure 2, and a common preventive screening test, the Pap smear, in Figure 3. By both of these trend lines, it is apparent that the copay cohort had substantially lower utilization indices than the no-pay cohort. In Figure 4, the use of prescription drugs, with a 50-cent copay requirement, shows similar relationships. All three of these types of service were associated with ambulatory doctor's visits, for which copayments were usually required.

Table 3, however, presents data for the two cohorts, with an important distinction. It applies to the hospital patients, and—while showing rates and indices separately for both cohorts—no actual copayment was required from either population, and the decision on hospitalization was made by the doctor.** The same data are shown in graphic form in Figure 5. The data in Table

** Our data are based on an unduplicated count of hospital *patients*, rather than admissions, which may have amounted to more than one for some patients.

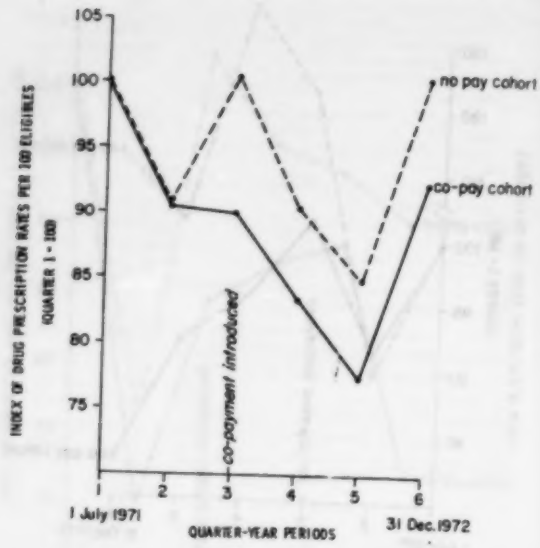

FIG. 4. Drug prescription rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

3 and Figure 5, in sharp contrast to trends in all previous tables, show that after introduction of copayment in January 1972 the index figures for the copay cohort leaped up to a *higher* level than those for the no-pay cohort. They remained at a higher level for three of the four copayment quarters. The drop in the final quarter may

TABLE 3. Hospital Patient Rates* for AFDC Families, by Copayment Status in California Medicaid Program, July 1971-December 1972: Number Hospitalized per 100 Eligibles per Quarter-Year, and Indices of Rates Based on Quarter 1 = 100

Quarter	Hospital Patients per 100 Eligibles		Index of Hospitalization Rates (Quarter 1 = 100)	
	No-pay	Copay	No-pay	Copay
1	3.56	2.54	100	100
2	3.07	2.09	86	82
Copayment Started				
3	3.12	2.37	88	93
4	2.88	2.14	81	84
5	3.05	2.29	86	90
6	2.70	1.71	76	67

* Data are based on an unduplicated count of hospital *patients* during a quarter year, rather than admissions, which may have been more than one for some patients.

Note: Illustrated graphically in Figure 5.

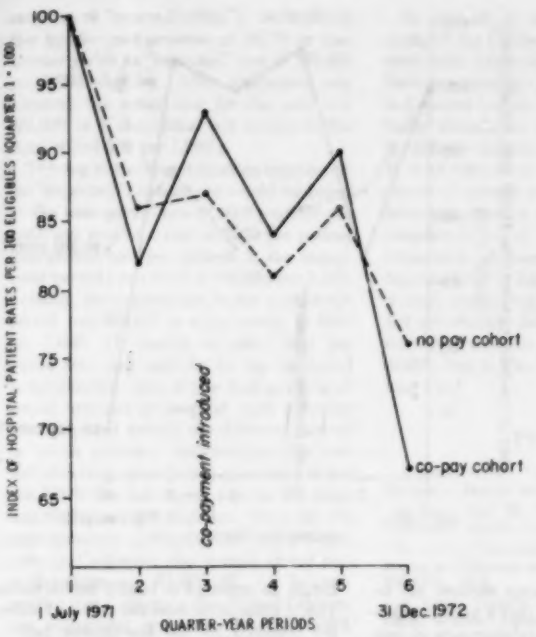

FIG. 5. Hospital patient rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

simply reflect the completion of hospitalizations in the previous three quarters for persons needing such care, as well as the usual overall drop in hospital use around the Christmas holiday season.

Figure 6 presents the hospitalization rates on another basis. It shows the trend of indices for all diagnoses except those related to pregnancy. The latter may be regarded as "nature-generated" and relatively independent of a doctor's judgment in modern American society. With these cases removed, it is apparent that the differentially higher indices of hospital use for the copay cohort are even greater in three out of the four copayment quarters than for the total of hospital patients shown in Figure 5.

Discussion

These findings suggest that the effects of copayment requirements for ambulatory services (and prescriptions) in a medical care program for low-income families were to exert a deterrent effect on demand or utilization. The inhibiting effect applied to office visits—the bedrock of general medical care—and also to typical diagnostic tests (urinalyses), to preventive procedures (Pap smears), and to drug prescriptions. Easy access to and use of general ambulatory doctors' services are widely considered to have preventive value, by permitting prompt diagnosis and treatment of an illness before it becomes more serious.

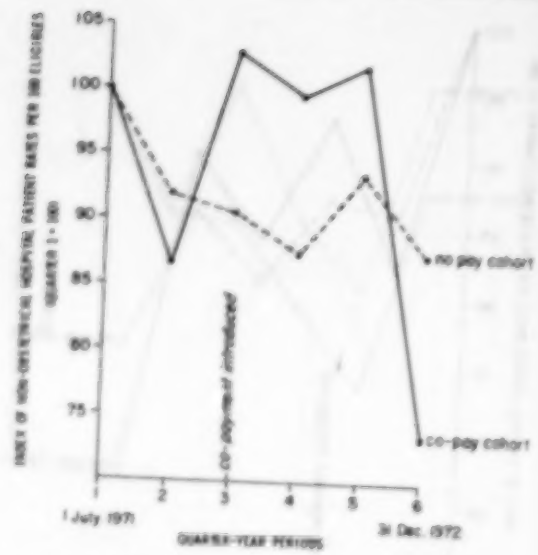

FIG. 6. Hospital patient rates for all non-obstetrical admissions in AFDC families, by copayment status in California Medicaid program, July 1971–December 1972, indexes of rates based on Quarter 1 = 100.

When such ambulatory services are inhibited, it would seem that a price is paid—namely, a rise in the relative rate of hospitalization. It is likely that this elevated hospitalization rate is due to the postponement of ambulatory care, so that when the patient is finally driven to seek assistance, his case is more advanced and requires inpatient care. This interpretation is supported by the general observation in the U.S. National Health Survey of longer hospital stays among low-income persons, even for the same diagnosis, in the nation as a whole.[9] This is likewise associated with lesser rates of ambulatory doctor's care by the poor generally and is usually interpreted along the lines offered above.

A clear-cut reduction in diagnostic tests (urinalyses, Pap smears, and others) as well as ambulatory treatment (doctor visits and prescriptions)—as found in our study—could hardly be expected to benefit health status. This is quite aside from the pain and suffering involved for the low-income patient, who postpones seeking medical care at early stages of his illness.

These findings also have serious financial implications. Hospitalization is by far the costliest sector of medical care. A reduced rate of ambulatory care may yield short-term financial savings, but a subsequent increase in the rate of hospital use could more than outweigh these amounts.

To determine the net financial effect within the copayment cohort, we may estimate an expected cost to the State, based on the rate of office visits in the quarter preceding the initiation of copayment, which was on an annual basis 2,400 visits per 1,000 (much lower, incidentally, than the rate in the general population, and hardly justifying the State government's

assertion of "overutilization"). Multiplying this by the cost-per-visit of $8.79 in that quarter yields an "expected" cost of $21,096 per 1,000 eligibles. After copayment was initiated, the actual cost for the year was $21,008 or a theoretical net saving to the state of just $88 per 1,000.†

Turning to the hospitalization experience, the "expected" expenditure would be based on the base-period rate of 83.6 patients per 1,000 per year at a cost of $623 per patient (the annual cost per patient in the copayment period) or a total of $52,082 per 1,000. Actually, the expenditure in the copayment period was $53,017 or a net excess of $935 per 1,000. (It should be noted that this excess was due entirely to the increased hospitalization rate; if one took account of actual inflation of hospital costs over the precopayment period, the difference would be much greater.) Subtracting the estimated saving for ambulatory services of $88 per 1,000, the net excess cost to the state was $847 per 1,000 eligibles. Thus, for the approximately 1,450,000 AFDC beneficiaries in California, the overall excess cost to the State was $1,228,150. (It is noteworthy that California discontinued the entire copayment procedure June 30, 1973, even though federal P.L. 92-603, effective January 1, 1973, officially permitted such copayment under certain circumstances.)

† In spite of the lower indices of office visit rates for the copay cohort, compared with the no-pay cohort (shown in Table 2 and Figure 1), it may be noted that the actual rate of visits of both cohorts (for epidemiological or other possible reasons) exceeded the precopayment rate during three out of the four copayment quarters. Thus, despite the $1 saving to the State for most visits, this explains the small differential in total expenditures.

In a word, it would appear from this study of the California Copayment Experiment with Medicaid beneficiaries that the State government's strategy was penny-wise and pound-foolish. Short-term savings for lower ambulatory care use were followed by definite increases in costly hospital use. It is of interest to note that this general course of events was predicted in a legal brief submitted in opposition to the copay program before it was instituted.[4] As the experience of many "health maintenance organizations" has repeatedly demonstrated, comprehensive medical care, without cost-sharing deterrents, is probably not only the best way to maintain a person's health, but is also most economical in the long run.[7]

References

1. Beck, R. G.: The effects of copayment on the poor. J. Human Resources, publication pending.

2. Brian, Earl W.: The Medi-Cal Reform law. California's Health, April 1972, p. 3.

3. ———: Government control of hospital utilization: a California experience. N. Engl. J. Med. 286:1340, 1972.

4. Buffer, Patricia, *et al.*: Attorneys for California Welfare Rights Organization: California's Copayment Waiver Proposal. Los Angeles, August 17, 1971.

5. Hall, Charles P., Jr.: Deductibles in health insurance: an evaluation. J. Risk Insurance 33:253, 1966.

6. Newhouse, Joseph P., Phelps, Charles E., and Schwartz, William B.: Policy options and the impact of national health insurance. N. Engl. J. Med. 290:1345, 1974.

7. Roemer, Milton I., and Shonick, William: HMO performance: the recent evidence. Health and Society, Summer 1973, p. 271.

8. U.S. National Center for Health Statistics: Medical Care, Health Status, and Family Income. Public Health Service, Washington, 1964.

Mr. WAXMAN. Thank you for your testimony.
Ms Bennett?

STATEMENT OF LaNITA A. BENNETT

Ms. BENNETT. My name is LaNita Bennett and I am a paralegal with Legal Services Corp. of Alabama in Anniston, Ala.

I have been a paralegal for the past 2½ years and have been a resident of Alabama all of my 28 years. As I am the most interested and experienced in public benefits and medicaid cases in our office, I have been an advocate for numerous low-income Alabamians in my area who have experienced difficulties with medicaid.

Alabama's medicaid program has a history of problems. There has been one funding crisis after another since 1975. The program is extremely limited in scope; there is no medically needy program and there are many optional services not covered.

Since our payment standard in Alabama for the aid to dependent children program is the second or third lowest in the country, a family of seven on ADC gets $236 a month, one poor elderly person receiving SSI now gets $238, many poor families do not even get medicaid here although they would in most other States.

Thus, to dispel any notions that Alabama is overly generous in the extent and coverage of its medicaid program, I would point out that medicaid recipients here make up 17 percent of our low-income population and 4 percent of our total State population, as compared to national averages respectively of 59 percent and 8 percent. Only three States cover a smaller percentage of their State's low-income population. Only four States provide fewer than the nine optional services which Alabama offers.

It is also significant to stress that Alabama's Federal matching percentage for medicaid is the third highest in the country, or about 73 percent. This means for every dollar of medicaid expenditures, Alabama is paying only 27 cents while the Federal Government is picking up the lion's share.

Just since last fall, the medicaid program in Alabama has implemented cutbacks in practically every area of service: Covered in-patient and out-patient hospital days have been limited once again; over 300 prescription drug items were removed from the approved Drug Code Index, based almost exclusively on fiscal rather than medical criteria.

Indeed the whole program was near collapse, subject to termination of all optional services in April 1980, and the entire program by June 1.

Faced with the ghastly possibility of eviction of thousands of nursing home residents should funding become unavailable for medicaid, the Alabama Legislature barely bailed out the program. Yet as over $30 million of next year's appropriation was designated only conditional, predictably there will be another medicaid crisis in 1981 in Alabama too.

Faced with the rapid inflationary spiral in health care costs and massive increases in our State's medicaid budget, the Alabama Legislature responded by imposing further limitations on covered medicaid programs as a method of cost containment.

One act mandated a $2 copayment for visits to physicians and the other medical practitioners; a second act required an increase

from the previous copayment of 50 cents per prescription drugs to the maximum allowable by Federal regulations, as high as $3 per prescription drug.

These acts requiring additional copayments for drugs and new copayments for doctors visits were challenged in litigation brought by my legal services program on behalf of the numerous Alabama medicaid recipients adversely affected by such legislation.

While the litigation is still pending, both a temporary restraining order and a preliminary injunction were issued by the Federal judge concerning the copayments for doctors' visits. The judge found that imposition of these copayments "would cause irreparable harm to the health and well being of medicaid recipients in Alabama.

Now, the same Alabama legislators responsible for the copayment acts enacted in our State, along with the medicaid commissioner, have prevailed upon U.S. Representative Richard Shelby and the entire Alabama congressional delegation to sponsor H.R. 7029 to amend the Social Security Act to freely permit copayments for any medical services a State offers its medicaid recipients.

On behalf of countless medicaid recipients in Alabama, I want to voice my firm opposition to H.R. 7029. The articulated purpose of copayments is not to promote the health care of low-income citizens but to save the State money. It cannot be doubted that copayments are a simple tool to discourage Alabama's poor from seeking the medical attention they need as part of an overall plan to decrease the State's costs by decreasing the amount of medicaid benefits the State must pay.

Medicaid cutbacks hurt people. This may seem like an obvious proposition. But judging from the cutback epidemic of the past few years, it doesn't seem to make much of an impression on enough State policymakers, the Federal officials who monitor State actions, or Congress.

During the course of three lawsuits we have filed in 1980 challenging medicaid cutbacks in Alabama, I have prepared several affidavits on behalf of my medicaid clients. These affidavits attest to the extreme hardship my clients were experiencing due to their numerous disabling medical conditions and the very high cost of prescription drugs and other medical expenses.

Additionally, I read about two dozen affidavits written by my colleagues on behalf of medicaid recipients all over Alabama. We plan to submit some of these affidavits to the subcommittee, Mr. Chairman, for inclusion in the record on H.R. 7029. [See p. 125.]

All of these affidavits and my countless personal experiences in assisting and representing medicaid recipients in Alabama all point to the same conclusion: These low-income individuals simply cannot afford to pay even a modest copayment fee for medical services under medicaid. If H.R. 7029 were enacted and States passed copayment legislation such as the act passed by the 1980 session of the Alabama Legislature in Alabama imposing a $2 copayment on doctors' visits and other medical practitioners, then I believe these recipients would be deterred from seeking the medical attention they need.

I would like to read into the record the short and eloquent affidavit of Annie Bell Moore as a symbolic "tip of the iceberg" of a typical elderly medicaid recipient.

My name is Annie Bell Moore. I am 73 years old. I live at Route 2, Hartford, Ala. My income is $204.40 monthly. I take medicine for blood, swelling, back and head pain. If I did not take medication, I would black out, be too dizzy to get out of bed and my back and head would constantly ache. I must depend on medicaid payment to obtain my needed medication.

I would like the committee to take a minute to read the comments by two elderly Montgomery recipients, contained in the Montgomery newspaper article attached to my statement, entitled "Medicaid Difference Between Having and Doing Without for Many Alabamians."

Mrs. Cora Dorsey, an 83-year-old diabetic with severe arthritis and only one leg stated: "I don't know how I'm going to do it—buy medicine. I don't take it like I'm supposed to now because I can't pay for it."

I hope the subcommittee will give serious consideration to the ramifications of H.R. 7029 upon the lives of thousands of poor, sick or elderly medicaid recipients all across the country, and will decide to not recommend that this legislation be enacated at this time.

Mr. Chairman and distinguished Representatives, I am also strongly opposed to H.R. 7030 which, if passed, would terminate medicaid benefits for up to 1 year for individuals determined to have abused or defrauded the medicaid program. The problem with H.R. 7030 as we see it, is that who knows what is meant by the term "fraud"? There is a lack of any viable, proper standards in this legislation. Is there any intent? How do you prove it? Is the intent clear cut? Is intent required? Who has the burden of proof? Congress needs to develop standards for proof of fraud and not leave this responsibility up to individual States.

Most disturbing is the proposed change whereby such a finding of fraud or abuse would be made at an administrative hearing conducted by the State medicaid agency, rather than a criminal prosecution in a court of law.

In Alabama, for example, the administrative hearing process of our medicaid agency is persistently flawed. Consequently, to allow a determination of fraud to take place at such a hearing rather than a criminal proceeding would be disastrous.

To cite but one brief example, in mid-July, one of LSCA's attorneys in Florence, Ala. requested an administrative hearing. This request was filed on behalf of the child and her mother after the child had been screened by the medicaid early and periodic screening diagnosis and treatment program and found to need orthodontic treatment. The first request for a hearing was denied. Her attorney then requested reconsideration of that decision. The medicaid agency sent the attorney a letter which told him in the second paragraph that the decision to dismiss his fair hearing request remained firm.

The fourth paragraph of this letter informed him that the request for a fair hearing was still pending. Also, the medicaid agency's in-house counsel asked this attorney if he were trying to bankrupt Alabama's medicaid program by filing such a request for orthodontic treatment.

Another problem with the medicaid administrative hearing process in Alabama concerns the lack of independence of the hearing officer. At medicaid fair hearings held in October 1979 before another round of cutbacks were implemented, the hearing officer continually consulted with an attorney who was at the hearing representing the medicaid agency. How could this hearing officer be a neutral arbitrator to independently ascertain whether there is the requisite amount of proof to indicate that a recipient had abused or defrauded the medicaid program?

In a recent telephone conversation to the medicaid fraud and abuse investigation unit in Montgomery, Ala., I was informed that 95 percent of the fraud and abuse is committed by providers and only 5 percent or less by any medicaid recipient. The investigator told me that to the best of his knowledge no recipient had ever been terminated from the medicaid program for fraud or abuse. Medicaid recipients are not criminals. They are poor, sick, and elderly people.

To compare H.R. 7030 to the other public assistance programs, it is revealing to note that in the Aid to Families With Dependent Children, food stamps, and SSI programs, an individual cannot lose his or her eligibility, even for fraud, if there is a financial need. The agency can merely recoup overpayments.

Perhaps we need uniform standards among all these programs, including medicaid, to determine what is fraud, who has the burden of proof, and what is the standard of proof in view of the severe sanctions imposed.

Thank you for the opportunity to present our views. I will be pleased to respond to any questions you might have.

[Testimony resumes on p. 161.]

[Attachments to Ms. Bennett's prepared statement follow:]

Montgomery (Ala.) Advertiser

Medicaid difference between having and doing without for many Alabamians

By KATHY BEASLEY
Advertiser Staff Writer

"Continued funding of optional Medicaid programs in Alabama could be the difference in some persons now on the program being able to afford necessary medicines — in some cases, life-saving medication.

Ornie Brown of 2114 W. Jeff Davis Ave. said he had no way to pay for the four prescribed medicines he takes unless Medicaid funds cover the expense.

"I don't see how I'm going to pay for it," said Brown, a 78-year-old diabetic. "I've been taking it (insulin) all my life. If the pharmaceutical program is eliminated, he said, "I'll take it when I can. And, when I can't go on, I'll just leave this world."

Brown lives with family members but his only income is from Social Security. In addition to the insulin, he is required to take medication for a heart disorder and two types of medication for high blood pressure.

Brown said the benefits he receives from Medicaid is "all there is to get," but that does not pay for all of his medicine.

His family cannot afford to help him pay for the medication, Brown said, because it takes all of their income to pay other family expenses.

"I don't know how I'm going to do it (buy medicine)," said 89-year-old Cora Dorsey of 1138 Parsons St. "I don't take it like I'm supposed to now because I can't pay for it."

Mrs. Dorsey said she receives Medicaid assistance to help pay for the five types of medication she takes, but her benefits do not pay the total bill now.

A diabetic who suffers from severe arthritis and has only one leg, she has been prescribed insulin as well as medication for high blood pressure, dizziness, poor circulation and nerves.

Mrs. Dorsey lives with her sister, Nellie Peagler. Mrs. Peagler receives Medicaid funds for caring for her sister, but her monthly allocation recently was "cut way down," she said.

The women's only other income is from Social Security, which mostly goes to paying monthly household bills, Mrs. Dorsey said.

If Medicaid benefits are cut, Mrs. Dorsey said she will buy as much medicine as she can and hope it lasts until she can afford more.

Last Thursday, Medicaid administrator W.H. "Hoke" L. Kerns asked James to terminate services not mandated by the federal government that are provided by the Alabama program.

The two major optional services that would be terminated provide pharmaceutical and nursing home care. More than 200,000 persons currently receive these benefits, according to Kerns.

Without Medicaid assistance, many will not be able to afford needed medicines or the expense of nursing homes, said Robin Hanan, president of the Alabama League of Aging Citizens.

Hanan said he had received many calls from senior citizens have called him "crying because they are scared to death." Those in nursing homes with no family members to take them in "fear they will be put in the streets," and many will no longer to able to purchase drugs to alleviate pain, agony, misery and sleepless nights," he said.

Kerns requested the cutback in services after he was warned by the Legislature's Joint Fiscal Committee that Medicaid officials could face fines and jail terms if they do not stop deficit spending in the program.

Medicaid will have a $75 million deficit if the optional programs are not cut, and still will run out of money more than three months before the end of the fiscal year if they are cut, Kerns said.

The Medicaid program is partially funded through taxes on liquor, beer and cigarettes, as well as sales taxes.

State Rep. Alvin Holmes of Montgomery plans to profile three bills designed to generate more than enough tax money to aid the program and save the optional services.

Holmes is proposing a "nickel tax" on beer and cigarettes and charging sales tax on items now exempted.

The beer and cigarette taxes would be based on an additional 5 cents per 12-ounce can of beer and for each pack of cigarettes. The beer tax would generate $25 million and the cigarette tax would bring in $31.9 million, said Holmes.

Charging the state's 4-percent sales tax on most of the 60 items now exempted would add $205 million to the state's annual income, Holmes said. Gasoline, motor oil and motor fuel would remain exempt, while exemptions would remain on all 60 items for persons who are over 65, blind or crippled, he said.

exhibit 4a-1
IF252044a

AFFIDAVIT

1. My name is Annie Bell Moore.

2. I am 73 years old.

3. I live at Route 2, Hartford, Alabama.

4. My income is $204.40 monthly.

5. I take medicine for blood, swelling, back and head pain.

6. If I did not take medication, I would black out, be too dizzy to get out of bed and my back and head would constantly ache.

7. I must depend on Medicaid payment to obtain my needed medication.

her
Annie Bell X Moore
ANNIE BELL MOORE mark

witness: Kay Taylor, 167 S. Oates, Dothan, Ala

STATE OF ALABAMA

GENEVA COUNTY

Personally appeared before me, the undersigned authority, in and for said State and County, Annie Bell Moore, who being by me first duly sworn, doth depose and say that the statements contained in the foregoing Affidavit are true and correct.

witness Kay Taylor 167 S. Oates Dothan, Ala

her
Annie Bell X Moore
ANNIE BELL MOORE mark

Sworn to and subscribed before me this 1st day of February, 1980.

Kathy E. McGhee
NOTARY PUBLIC

88-689 O—80—

IN THE UNITED STATES DISTRICT FOR
THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PATRICE POTTER, et al.,

PLAINTIFFS,

vs.

FOB JAMES, et al.,

DEFENDANTS.

CIVIL ACTION NO.: 80-0154-N

AFFIDAVIT

STATE OF ALABAMA
COUNTY OF MONTGOMERY

Before me, the undersigned authority, in said State and County, personally appeared LILLIE WRIGHT, who, after being first duly sworn, deposes and says:

1. My name is Lillie Wright. I am 73 years old and live by myself at 1301 Adams Avenue, Apt. 707; Montgomery, Alabama.

2. I have been in poor health for so long that I cannot remember when my health was good, but I know that I have been receiving Social Security Widow's Benefits and disability benefits under Supplemental Security Income (SSI) for at least ten years.

3. I suffer from the following chronic conditions: diabetes, cirrhosis of the liver, thyroid problem, high blood pressure, blood clots in my leg and after I fell, eye problems (including a lack of tears), and arthritis. I was hospitalized for three days this month for a kidney infection. I have in the past, had an ulcerated stomach.

4. I take the following medications on a regular basis:

a) Nicobid: 2 times a day for swelling of my legs.
b) Proloid: once a day for thyroid condition.
c) Naprosyn: 3 times a day for swelling of legs.
d) Albee with C, a high potency Vitamin B complex, prescribed by my doctor.
e) Quinamm: once a day for leg cramps.

f) Insulin injection once a day for my diabetes.

g) Vitamin B-12 and liver injection once every 2 weeks.

h) Antivert as needed for nausea and dizziness.

i) Nalfon 3 times a day for blood clots in my legs.

j) Dyazide once a day for swelling.

k) Tylenol No. 3 as needed for eye pain.

l) Lopressor 2 times a day for high blood pressure.

m) HCTZ 2 times a day for swelling.

n) Vitamin C once a day which makes me feel better and helps my bowels to move.

o) Gantanol 4 times a day for my kidney infection.

p) Butisol taken about 4 times a week for nerves.

q) A cream for my face prescribed by my doctor.

r) Normal saliene solution used frequently because my eyes do not tear.

s) Ad Sorbotear eye drops used frequently.

5. I have to pay the entire cost of the following prescriptions: Nicobid, Albee with C, needles and syringes to inject insulin and Vitamin B-12, Vitamin B-12 and liver, Antivert, Vitamin C, Normal Saliene Solution, and Ad Sorbotear. These medications cost me at least $45 each month.

6. Medicaid also does not cover the soft contact lenses my doctor has said I must wear after my eye surgery. Each lens costs $150. I have had to buy four new lenses because they did not fit properly, and I lost them when they fell out. I bought insurance which covers lens replacement for $29 per eye. I still have to pay the $44 deductable each time I lose a lens.

7. I lost a lens at the end of this past May; and when I went to my doctor for a new one, he told me that only my other eye was insured. He would not give me a new lens until I paid $150. I had to go without the lens for 4 days because I did not have the money. I could not see very well and had a lot of pain without the lens. I only got the new contact after my children were able to come up with $150. I bought insurance for the other eye.

8. The doctor who has treated me for years does not accept Medicaid, thus I have to pay him everytime I see him. I do not want to change doctors because I like and trust my doctor. I have to go see an eye specialist in Birmingham this month. The last time I went, I had to pay him $68.

9. Last year, I spent at least $550 on health care, and I believe I will have to pay more this year since I now have to wear contact lenses as well as glasses.

10. I have been receiving bills from St. Margaret's Hospital for the surgery I had on my eyes. My attorney tells me I don't have to pay the bills because I was covered by Medicaid and Medicare at the time. Even though my attorney has told them this, I still get bills. I worry what may happen if I don't pay, but I don't have the money to pay them. I paid $36 to University Hospital in Montgomery and $46.50 to St. Margaret's because they kept billing me. I now know that the hospitals should not have billed me, but I still am getting some bills.

11. I get $163 from Social Security and $65 from SSI each month. Part of that goes for food since I only get $21 a month in food stamps. I have no savings, and I am not sure how I can continue to live on so little money. My children help me out already as much as they can.

12. I found out that I will have to pay more in co-payments because four of my prescriptions will cost more than $10.00:

a) Naprosyn - $33.00
b) Nalfon - $15.00
c) Lopressor - $11.00
d) Insulin - $15.00

13. I cannot afford to pay more for medicine out of my small income. If I did not have a charge account at my drugstore, I would not be able to get my medicine now. I owe my druggist about $25 now, and I do not know how much more I will be able to charge.

14. I am participating in this lawsuit to try and keep my drug bill from getting so high that I could not afford to buy all the drugs that I need. I am afraid not to take the medicines prescribed by my doctor because the medicines make me feel so much better, but I do not know what I can cut back on to pay for my drugs.

Lillie Wright
LILLIE WRIGHT

Sworn to and subscribed before me this 3rd day of June, 1980.

Sylvia A. Madison
NOTARY PUBLIC

AFFIDAVIT OF VERBIE CAULEY

STATE OF ALABAMA :
SS:
COUNTY OF MONTGOMERY :

Before me, the undersigned authority, in the said state and county, personally appeared VERBIE CAULEY, who, after being first duly sworn, deposes and says:

1. My name is Verbie Cauley, and I live alone at # 37 Briarcliff Road, Geneva, Alabama. I am 71 years old.

2. My income consists of $228.00 -- I receive $155.00 from Social Security and $73.00 from Supplemental Security Income (SSI).

I am being treated by a physician for the following chronic conditions: heart problems, high blood pressure, arthritis, digestive trouble, nerves, cataract in my right eye, trouble sleeping, and poor circulation in my legs.

4. I take the following medications prescribed by my doctor:

a. Probanthine with Pb -- 1 tablet 4 times a day for leg condition.

b. Butisol, 30 mg. -- 1 tablet four times a day for nerves.

c. Hydrochlorthiazine, 50 mg. -- 1 tablet a day for high blood pressure.

d. Purodigin, 0.1 mg. -- 1 tablet a day for heart condition.

e. Pronestyl, 250 mg. -- 1 tablet 4 times a day for heart condition.

f. Motrin, 400 mg. -- 1 tablet 4 times a day for arthritis.

g. Dolene compound 65 -- as needed for arthritis pain.

h. Drixoral - as needed for sinus.

i. Dalmane, 30 mg. -- 1 tablet each night for sleep.

j. Trihemic 600 vitamin supplement daily.

k. Quinamm - 1 tablet each night for leg cramps.

5. Medicaid does not pay for all of my prescriptions. I have to pay the total cost of Drixoral, Dalmane, and Trihemic 600.

6. My fixed-monthly expenses are $42.00 for rent, about $14.00 for telephone, $47.30 bank loan, and $20.00 for prescriptions not covered by Medicaid. After my fixed monthly expenses are paid, I

68-669 O—80—

have only $64.00 left to buy all my other requirements such as food over the $18.00 in Food Stamps, laundry supplies; soap, lotions, and other sundries; transportation and clothing.

7. In addition, I owe $340.00 for my son's funeral. My son had been crippled all of his life from polio and lived with me before he died at age 51. There was no insurance to pay the $1000.00 for his funeral. Because he was disabled, the government paid about $250 of the $1000.00. I have paid around $410.00 so far. The bank loan I pay was taken out to cover my son's medical expenses because he did not become eligible for a disability pension until after he died.

8. I buy my medicine at the Geneva Drug store. My pharmacist told me I now have to pay $3.00, instead of $.50, co-payment for the Motrin my physician prescribed for arthritis. I now will have to pay $1.00 co-payment each for the Pronestyl and Probanthine with Pb.

9. Because I have not had enough money to buy all of the drugs prescribed, I have cut down on most of them. Instead of taking four tablets each of Probanthine, Butisol, Pronestyl, and Motrin, I only take two tablets of each per day. This makes them last longer and cost less. I no longer take the Trihemic 600 vitamin supplement due to its cost. I cut down on my medicine several months ago.

10. I am very worried that I will not be able to continue taking my prescribed medicines because I cannot afford to purchase them out of my income since I will have to pay a higher co-payment. I have not bought any clothes for several years; it has been so long ago that I cannot remember when I last bought a dress. My clothes, however, need replacing and I will have to do without something to buy some more.

Verbie Cauley
VERBIE CAULEY

Sworn to and subscribed before me this 30 day of June, 1980.

Theresa Kay Taylor
NOTARY PUBLIC

my commission expires 4-23-84

AFFIDAVIT

STATE OF ALABAMA
COUNTY OF BALDWIN

Before me, the undersigned authority, in said State and County, personally appeared Gurvas Booker, who is known to me, and who after first being duly sworn, deposes and says that the following is true and correct:

My name is Gurvas Booker, and I reside at 103 W. 16th Street, Bay Minette, Alabama. I am 69 years of age. I am retired, and my only source of income is approximately $300.00 per month from the Social Security Administration. Aside from my own personal needs, I spend an average of $45.00 or $50.00 per month for medicine to control my high blood pressure.

I am the sponsor for my daughter, Joan Biggs, who is an invalid at Golden Dawn Nursing Home in Atmore, Alabama. I provide my daughter's personal needs, such as toothpaste, clothes, shoes, hose, and other necessities. I also buy her medicine each month: Elavil/$1.00; Lioresal/$2.00; Sinequan/.50¢; Modane/$3.51; Dulcolax Supp./$5.95; and Consyl Powder/$4.59. I spend an average of $17.56 per month on her medicine and about $20.00 per month for her visits to the doctor.

I visited with my daughter once a week until recently, but now, because the price of gas is so high, I can only afford to visit with her every two weeks. When I visit her, I take her fruit.

Joan's expenses run approximately $45.00 or $50.00 per month. I do not believe the $25.00 allocated for them by the State is enough. Because I am on a fixed income and have health problems myself, this expense is working a financial hardship on me. If prices continue to rise, and the medicaid co-pay is increased, I do not know where I will get the money to pay for these things.

Gurvas Booker
GURVAS BOOKER

Sworn to and subscribed before me this 2nd day of July, 1980.

Sim Hall
NOTARY PUBLIC

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PATRICE POTTER, et al.,	()	
PLAINTIFFS,	()	
VS.	()	CIVIL ACTION NO.: 80-0154-N
FOB JAMES, et al,	()	
DEFENDANTS.	()	

AFFIDAVIT

STATE OF ALABAMA)
COUNTY OF MONTGOMERY)

Before me the undersigned notary public in and for the State of Alabama personally appeared LELA P. WATKINS who, being duly sworn, deposes and says:

1. My name is LELA P. WATKINS and I am 80 years old. I now reside by myself at 2400-B Crossway Drive; Montgomery, Alabama. My husband, a minister, died in 1972. I am a former Sunday School teacher, and have previously done volunteer work for the PTA and School Board in Montgomery.

2. My sole source of income is $208.00 per month from Supplemental Security Income (SSI) and my husband's army pension. I also receive $33.00 worth of food stamps per month.

3. I suffer from chronic health problems including arthritis, diabetes, and a nervous condition. I have fluid in my right ear, and I have a presistent noise and pain in this ear.

4. I regularly take the following medications prescribed by my doctor:

(a) Indocin: two tablets three times a day for my arthritis;

(b) Mellaril: one or two tablets at bedtime for my nervous condition;

(c) Insulin U-100: thirty units each day for diabetes; syringes and needles are necessary for these injections.

(d) A vaginal cream;

(e) Bengay Ointment: used frequently for arthritis pain and stiffness;

(f) Tylenol: taken as necessary for arthritic pain;

(g) Chardui Tablets: taken as needed to help me rest;

(h) Laxatives;

(i) Nerve Pills: one or two tablets (the exact name of which I can't remember), at bedtime;

(j) Thisonex: a foot-soaking medication for diabetes;

(k) Aspirin Cream: a cream used for my arthritis.

5. Medicaid does not cover the cost of all of my medications. Although it does cover the Indocin, Mellaril, Insulin U-100, and vaginal cream, I now have to pay a $1.00 co-payment for these medications. Medicaid does not cover the other medications I have to buy. I pay $1.37 per bottle for the Bengay (I have to buy two bottles each month); $2.00 per bottle for Tylenol; $1.80 per bottle for Chardui; $1.99 per 30 laxative pills/ and $6.00 per bottle for the nerve pills. The Thisonex costs $4.70 and the Aspirin Cream costs $2.23. Also, the syringes and needles I need for my insulin injections cost $5.40 for a package of 30. I do not have a charge account at the pharmacy, and cannot buy the drugs unless I can pay for them immediately. For this reason, I have not been able to but the new nerve pills prescribed by my doctor.

6. Also, my vision is getting worse, and I now have to buy a new pair of glasses. Medicaid only will pay for new glasses once every two years, and I would have to go without the correct lenses until next March to get Medicaid to pay for them.

7. My doctor has told me to eat a special diet for my diabetes; however, I cannot affort to buy the fresh fruits and vegetables and and meat that I need to eat. My drug bill continues to increase because some of these drugs are not covered by Medicaid and because of the higher co-payment. I also have not been able to buy needed clothing.

Lela P. Watkins
LELA P. WATKINS

Sworn to and subscribed before me this 3rd day of July, 1980.

Sylvia H. Mason
NOTARY PUBLIC

My commission expires: 4-8-84

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PATRICE POTTER, et al.,
Plaintiffs,

vs. CIVIL ACTION NO.: 80-0154-N

FOB JAMES, et al.,
Defendants.

AFFIDAVIT

STATE OF ALABAMA)
)
COUNTY OF MONTGOMERY)

Before me the undersigned notary public in and for the State of Alabama appeared SOPHIE VINSON who, being duly sworn, deposes and says:

1. My name is SOPHIE VINSON and I reside by myself at 1409 Bragg Street, Montgomery, Alabama. I am 79 years old. I used to work, but now I am not able to do so. I worked in a hotel for 16 years and also for 2 1/2 years for Trailways.

2. My health is not as good as it used to be. I suffer from the following conditions: arthritis, poor circulation (especially in my eyes and feet) and allergies. I only have had one kidney for five or six years so I have to be checked regularly by a kidney specialist. The arthritis has caused my right hand to become numb, and now I cannot use that hand very well.

3. My doctor has prescribed the following medications:

(a) Hygroton: one tablet each day for high blood pressure;

(b) Clinoril: two tablets each day for arthritis;

(c) : one tablet each day for circulation;

(d) Throat Drops: two drops as needed for allergies.

4. I receive $228.00 each month from Social Security and Supplemental Security Income (SSI). I also get $18.00 in food stamps.

5. I now have to pay more for my drugs because the co-payment has increased to $1.00 for the Hygroton and Clinoril. I have had to

go to a Podiatrist because of poor circulation in my feet. I had to pay $26.50 for the Podiatrist. I also was charged $7.00 for my pap smear this year.

6. My income is not sufficient to take care of all of my needs. I cannot afford to buy any clothes even though I need new ones. I did not have enough money as it was and now I have to pay more for my drugs.

Sophie Vinson
SOPHIE VINSON

Sworn to and subscribed before me this 31 day of July, 1980.

Sylvia D. Madden
NOTARY PUBLIC

My commission expires: 4-8-84

AFFIDAVIT OF REBECCA SMITH

STATE OF ALABAMA :
: SS:
COUNTY OF MONTGOMERY :

Before me, the undersigned authority, in said state and county, personally appeared REBECCA SMITH, who, after being duly sworn deposes and says:

1. My name is Rebecca Smith. I am 57 years old and reside by myself at 3720-A South Smiley Circle, Montgomery, Alabama. I have only a 7th grade education and have worked as a dishwasher and salad maker. I have one daughter who lives with her two children. My husband died in 1969.

2. I am no longer able to work because of poor health. I suffer from the following chronic conditions: diabetes, hypertension, pernicious anemia with ataxia and muscle weakness, upper gastrointestinal bleeding. I have had diabetes and hypertension since 1968. I am receiving Supplemental Security Income (SSI) because of my disabilities.

3. I have to take the following medications prescribed by my doctor:

a) Insulin: 100 units injected each day for diabetes.
b) Novafed: 3 tablets per day as needed for throat.
c) Larotid: 2 tablets per day for a throat infection.
d) Allergy shots at least once a week and sometimes twice a week.

4. Medicaid does not pay for all of the drugs prescribed. Each month I have to pay about $5.00 for the syringes and needles used to inject insulin and about $6.00 for the Novafed (this amount may be higher depending upon how much my throat hurts).

5. My sole source of income is $208.00 each month from SSI and $30.00 in food stamps.

6. Besides purchasing the syringes and Novafed and paying the co-payments of other drugs, I have the following monthly expenses; rent - $38.00, electricity - $23.00, gas - $4.00, telephone - $25.00, life insurance - $22.00, payment for washing machine - $22.00, payment for furniture - $30.00, other installment payment - $17.00. I have only $16.00 left to buy everything else that I need including clothes, transportation, groceries not covered by food stamps, church

contributions, and toiletries.

7. My doctor has told me to follow a special diet for my diabetes, but I cannot afford to buy the meat and fresh fruits and vegetables on the diet. My insulin dosage has been increasing -- from 30 units to 55 units -- to the present 100 units.

8. I owe doctor bills of $125.00, $239.00, and $170.00 from when I was hospitalized in February, 1979. I have to pay them since I was not then on Medicaid. I do not have the money to pay these doctors, but I keep receiving bills and telephone calls about them which worry me a lot.

9. I do not have enough money to go around. I had to pay a $25.00 fee to get my telephone reconnected after the phone company refused to wait one more day which was when I got my SSI check. My last gas bill was $12.78 which was almost $9.00 more than usual. I called to have the meter checked, and I was told that I would have to pay to have it checked. I do not have the money to have it checked, but I also do not have the money to pay higher bills.

10. When I went this month to the drug store to get my insulin, I had to pay $1.07 instead of the usual $.50 co-payment. I had gotten some card from Medicaid last month; but, since I do not read too good, I did not know it meant I had to pay more for my drugs.

11. I just do not know how I am going to pay for everything. When I don't pay a utility bill, it gets shut off and I have to pay more to get it turned on. I get threatening calls and letters about other bills. My food stamps were late this month so I have had to pay for food.

Rebecca Smith
REBECCA SMITH

Sworn to and subscribed before me this 30th Day of June, 1980.

Doris Ina Jackson
NOTARY PUBLIC

IN THE UNITED STATES DISTRICT FOR
THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PATRICE POTTER, et al.,	§	
PLAINTIFFS,	§	
vs.	§	
FOB JAMES, et al.,	§	CIVIL ACTION NO.: 80-0154-N
DEFENDANTS.	§	

AFFIDAVIT

STATE OF ALABAMA
COUNTY OF MONTGOMERY

Before me the undersigned notary public in and for the State of Alabama personally appeared ETHEL PERKINS who, being duly sworn, deposes and says:

1. My name is ETHEL PERKINS and I am 50 years old. I live at 5435 Cleveland Avenue; Montgomery, Alabama with four of my children and a granddaughter. My children's ages are 16, 15, 11, and 10. My granddaughter is 6 years old.

2. I have a ninth grade education and have worked as a domestic. I had to quit my last job after 11 1/2 years because of poor health, and I have been unable to work since. I have had high blood pressure since 1969. I also have other chronic health problems including steoarthritis in my knees and back, headaches, bad nerves, respiratory problems, and black-out spells. My left elbow was crushed when I fell down 14 concrete steps requiting several operations. My arm now swells and hurts me a lot. I also had surgery on my wrist for a pinched nerve.

3. I take the following drugs prescribed by my doctor:

a) Nalfon - 2 tablets 3 times a day for arthritis.
b) Dyazide - once a day for high blood pressure.
c) Roboxisal - 2 tablets 4 times a day as a muscle relaxant.
d) Phenergan with Codiene - as needed for respiratory problems.
e) Triavil - tablet 3 times a day for nerves.
f) Seosol - 1 tablet a day for blood deficiency.

4. Medicaid does not pay for two of my medications: Phenergan, which costs $5.50 a bottle, and Robaxisol, which costs $12.58 per 100.

5. My sole source of income is $207 I receive as Aid to Families with Dependent Children (AFDC). My family of six also receives $259 in food stamps.

6. Out of the $207 I receive, each month I have to make the following payments, in addition to buying my drugs: telephone - $20; electricity - $13.35; gas - $23.00; water - $8.00; loan for stove and refrigerator - $25.38; going to laundromat - $36.00; bus fare for son in summer school - $18.00; juice for son in summer school - $4.20; non-food groceries not covered by food stamps - $20.00, and life insurance - $14. 92.

7. After all of these bills are paid, I have hardly anything left to pay for transportation for the rest of the family, clothing, recreation, and other things needed by my family. I try to put clothes on lay-away, but that is not always possible. I just had to buy sneakers for all of the kids because they had outgrown their old ones.

8. We just moved to public housing on April 11, 1980 and I had to pay people to help move us. I also had to pay extra to get the telephone transferred and put $15.00 deposit for water.

9. I cannot afford to pay more for my prescriptions which my doctor says I have to take. Medicaid quit paying for my cough syrup last December so I had to start paying for it as well as for the Robaxisol. My doctor told me to get a tooth pulled because the bad tooth was making my arthritis worse, but I did not have the money to go to a dentist.

10. After I received the notice in May saying that I would have to pay more co-payment, I cut down on the number of Triavil from 3 a day to 2 a day to try and make my supply last longer. I now will have to pay $1.00 co-payment for Triavil instead of $.50. I have been out of Robaxisol for a week and will have to go without until I can get the money to buy the. I have a charge account at my drugstore, and without it, I would not be able to ever buy my medicine. I can only charge an amount that I can pay each month, so I cannot charge anything more now.

11. I do not feel as well since I have quit taking all of the medicine my doctor prescribed for me. My children need things also, but I do not have enough money to get everything.

Ethel Perkins
ETHEL PERKINS

Sworn to and subscribed before me this 30th day of June, 1980.

Ann Jean Jackson
NOTARY PUBLIC
My commission expires: 5/84

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PATRICE POTTER, et al., individually and on behalf of all others similarly situated,	()	
Plaintiffs,	()	
vs.	()	NO.: _____
FOB JAMES, Governor of the State of Alabama, as the "single state agency" for administration of the Alabama Medicaid Program; and W.H. KERNS, as Commissioner for Medical Assistance for the State of Alabama,	()	
Defendants.	()	

AFFIDAVIT OF PATRICE POTTER

STATE OF ALABAMA)
)
COUNTY OF MONTGOMERY)

My name is PATRICE POTTER and I am twenty-one (21) years old. I am a Plaintiff in this case objecting to the imposition of a $2.00 co-payment for medical services provided by a physician or other medical practitioner. I moved to Montgomery County, Alabama in January, 1980 with my mother from Atlanta, Georgia. Temporarily we are staying with my married sister and her family at 6848 Wampold Court, Montgomery, Alabama 36116, until we can locate and afford our own home.

I was born with one non-functioning kidney. The other kidney functions at only 4% capacity. During my childhood I had recurring sore throat, backaches and bladder infections but my physicians in Columbus, Georgia never diagnosed the problem with my kidneys. I received lots of antibiotics as a result of which my blood pressure became very elevated. Finally at age 15 my Urologists did discover that I had a reflex problem in my left kidney -- the valve between the bladder and the kidney was not working correctly. These physicians

operated on my left kidney for reflex and put a tube in. This surgery was done incompetently and the tube was left in a bent position such that I began having convulsions. While the doctors thought the left kidney would heal it never did. Temporarily I had a nephrostomy tube, a catheter which drained to a bag on my left. I was in the hospital for five months at that time. During this lengthy hospitalization I became addicted to Demerol because it seems that all three physicians had standing orders for 50 milligram dosages and I received three times the quanity which was prescribed for me.

Finally, my mother sought the assistance of a new Columbus, Georgia general practitioner who referred me to a Neurologist and Nephrologist (kidney specialist) at Eggleston Children's Hospital, part of Emory University in Atlanta. Finally the Nephrologist at Emory diagnosed that my right kidney had never developed, that my left kidney was only functioning at 4% capacity, that I would need hemodialysis, and that my bladder was very stretched and infected and that surgery was required to put in an Ileoconduit to replace my bladder. At age 15 surgeons at Emory University removed my right kidney and put in a Fistula which is necessary for me to be connected to the hemodialysis machines.

Since age 15 I have had renaldialysis three times a week. The very first day I was dialysed in March, 1974, I had several focal seizures and a serious stroke which paralized my left side for months. I could not have hemodialysis as a result and had Peritonealdialysis through the outer covering of my stomach for six months. During this time I under went extensive physical therapy. Finally I was able to resume hemodialysis.

In 1976 I underwent surgery to receive a kidney transplant from a cadaver. The transplant only worked for 48 hours and then my body rejected this kidney. Moreover, I got a serious infection from the incision. Thus I resumed renaldialysis. Three months later my left kidney was removed. In January, 1980 my mother and I moved from Atlanta, Georgia to Montgomery, Alabama. Currently I receive hemodialysis three times a week at a Montgomery dialysis center. My

physician there is a Nephrologist, who also functions as my primary care physician for any other miscellaneous ailments and medical problems. I usually see this Nephrologist or his assistant every time I am dialyzed. He is a Medicaid provider and is reimbursed at the Medicare rate, set at $300 per month based on an average of 13 office visits per month.

Next week I have an appointment with the kidney transplant specialist surgeon from the University of Alabama at Birmingham Kidney Transplant Center, affiliated with UAB's Medical School. I will undergo a week-long session of intensive testing from head to toe. Hopefully I will be placed on the waiting list for a kidney transplant in Alabama and perhaps be able to end my six year ordeal of hemodialysis then.

I also am afflicted with renalostreodystrophy, a disease causing deterioration of my bones, as a result of my End State Renal Failure. In 1977 I broke my left Metatarsal and had a cast on for a year because the bone was not healing properly. Then I wore a brace, which in turn caused my left tibia to fracture. In March 1979 I wore a long leg cast for a month. From March, 1979 to March, 1980 I wore a long leg brace again. In June, 1979 I broke my arm and it did not heal properly. Consequently, in March 1980 an Orthopedic surgeon in Montgomery performed an operation to insert a rod in my left shoulder. I was hospitalized for a week at that time. Since my release from the hospital on March 12th I have been in a wheelchair unable to walk because my muscles are so weak. It has been over a year since I walked without a brace. I have started intensive physical therapy to exercise my legs and learn to walk again at the Rehabilitation Center in Montgomery.

Currently, I take three different medications required as vital components of my hemodialysis treatment, none of which is covered under the Alabama Drug Code Index for Medicaid Recipients unless through prior authorization. I also have a prescription for a tranquilizer which is likewise not paid for under the Alabama Medicaid Prescription Drug Program. Furthermore I take Phenobarbital to control my seizures, Indocin for reducing pain and swelling in my joints,

Folic Acid and Rocaltrol to replace vitamins drained from my body during the process of hemodialysis.

In view of my multiple disabling medical conditions, I must see my physicians at least 15 times per month. As my income is limited to a small amount of Social Security and SSI benefits I am worried about the possibility that I would have to make so many co-payments for physician services each month. I already spend a significant part of my monthly income on prescription drugs, medical equipment and services which are not covered by the Medicaid and Medicare programs. If I had to pay $30 a month for co-payments for physicians' visits, this will cause me a financial hardship and no doubt force me to cutback on expenses for other necessities.

Patrice Potter
Patrice Potter

Sworn to and subscribed before me this 9th day of April, 1980.

Jean C. Smith
Notary Public
My commission expires: May 2, 1982

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

ARLENE CHEESEBREW, et al., individually and on behalf of all others similarly situated,

Plaintiffs,

vs.

NO. _____

FOB JAMES, Governor of the State of Alabama, as the "single state agency" for administration of the Alabama Medicaid Program; and W.H. KERNS, as Commissioner for Medical Assistance for the State of Alabama,

Defendants.

AFFIDAVIT OF ARLENE CHEESEBREW

STATE OF ALABAMA)
)
COUNTY OF BALDWIN)

Before me, the undersigned authority, in said state and county, personally appeared ARLENE CHEESEBREW, who, after being first duly sworn, deposes and says:

My name is Arlene Cheesebrew. I am a Plaintiff in this case, challenging the imposition of $2.00 co-payments for medical services provided by physicians, mandated by Act Number 80-126 of the 1980 Regular Session of the Alabama Legislature. I live at Post Office Box 48, Magnolia Springs, Alabama 36555. I am 26 years old, and I've lived in Baldwin County all of my life. I am presently married to Clause Cheesebrew.

I presently have three children by a former marriage, Wesley Hubbart, age six; Bryant Hubbart, age five; and Terry Hubbart, age three. I am presently receiving Medicaid benefits for these three children. I have tried on numerous occasions to get my former husband to provide support and financial assistance for medical costs for the children, but he has provided little if anything.

pages tightly bound

In September of 1979, my house suffered extensive damage from Hurricane Frederic. We have had to replace the whole roof and insulation. The entire roof leaks, and the house has been practically uninhabitable since that time. We were unable to obtain temporary housing.

Around January, my husband severed his finger with a handsaw. Because he is a construction worker, he has been unable to find a job since that date.

All three of my children have medical problems. Last year Wesley was severely burned, and I have outstanding hospital bills of thousands of dollars for his treatment. Wesley still receives treatment for these burns, and each month I must buy pads for his burns.

Bryant must have asthma medicine every other week and he has a hormonal problem which has prevented his genitals from developing. When he reaches the age of twelve, he will need to receive shots for treatment of this problem.

Terry has a chronic skin disease which requires medicine costing on the average $30.00 every two weeks. We have been unable to get his medicine in the last few months, because we cannot afford transportation to Pensacola for the prescription.

Terry and Bryant have eye problems. Terry needs surgery to correct his, and Bryant will need glasses when he attends school. Both of these children are chronically anemic.

All of these problems are in addition to the typical illnesses such as flu and colds. I would say, on an average, in a single month one or all of my children must go to the doctor every other week.

Because Medicaid pays for very little of their medicine now, I do not believe I can continue to provide their medical assistance if I were required to pay money every time I took them to the doctor.

I attended Fairhope High School for slow learners and I

68-669 O—80——11

have no job skills. I have often looked for work, but have not been able to find a job.

My husband and I are barely making ends meet now. I have not even attempted to make payments on Wesley's outstanding hospital bill. There is no way that our financial situation will allow me to make a $2.00 payment every time one of the children must go to the doctor's office.

Arlene Cheesebrew
Arlene Cheesebrew

Sworn to and subscribed before me this 7th day of April, 1980.

Ella Jo Bobbitt
Notary Public.
My commission expires:
12/5/82

AFFIDAVIT OF ARLENE CHEESEBREW - SUPPLEMENTAL

STATE OF ALABAMA :
SS:
COUNTY OF BALDWIN :

Before me, the undersigned authority, in the said state and county, personally appeared ARLENE CHEESEBREW, who is known to me, and who after first being duly sworn, deposes and says:

1. I reside in Magnolia Springs, Baldwin County, Alabama, with my husband Pete Cheesebrew and my three sons by a previous marriage--Wesley Hubbart, age six; Bryant Hubbart, age five; and Terry Hubbart, age three.

2. Because my former husband does not provide any financial support for the children, I receive $118.00 a month in Aid to Families with Dependent Children (AFDC). All three boys are covered by Medicaid.

3. We all have medical problems:

   a. Wesley was severely burned last year, and he must receive continuous treatment.

   b. Bryant has had asthma since birth, but it was not diagnosed until eight months ago. A vision defect prevents him from seeing out of one eye. He needs corrective surgery. Also, he suffers from chronic anemia. Bryant gets colds frequently which makes his asthma worse. A hormonal problem has caused his genitals not to develop. He will have to receive shots for this when he is 12 years old.

   c. Terry has had asthma since birth, and it was diagnosed about five months ago. He frequently catches colds, which complicates the asthma. In addition, he is chronically anemic, has a speech problem, has a chronic skin condition, and has a vision problem which will require corrective lenses when he starts school.

   d. I have suffered from hay fever since childhood.

   e. My husband severed his finger with a saw. He received inadequate treatment after the accident, and now the bone is sticking out.

4. Wesley requires two kinds of pads for treatment of his burns.

5. Bryant takes the following medications:

   a. Elixicon--1 1/4 teaspoons 4 times a day for asthma.

   b. Alupent syrup--1 teaspoon 4 times a day for asthma.

   c. Phenergan--1 teaspoon 3 times a day for asthma.

   d. Novafed--A syrup--1 1/2 teaspoons every 6 hours for asthma.

e. Bronchometer 10 mg.--3 inhalations every 20 minutes for three doses as needed for asthma.

f. SS tonic for anemia.

6. Terry has to take the following medications regularly:

a. Alupent syrup--1 teaspoon 3 times a day.

b. Slo-Phyllin 80--3 1/2 teaspoons every 6 hours.

c. Bronchometer 10 mg--3 inhalations every 20 minutes for three doses as needed for asthma.

d. Alphakerr oil daily for skin problem.

e. Special soap daily for skin problem.

f. SS tonic for anemia.

7. I take over-the-counter antihistamines for my hay fever, because I cannot afford to go to a doctor or get the prescriptions filled.

8. My husband cannot afford to have his finger treated. He has to take Tylenol #4 frequently for the pain.

9. Medicaid does not cover all of the children's prescriptions: neither of the two pads needed by Wesley; the SS Tonic used by Terry and Bryant, nor the alphakerr oil and special soap needed by Terry. The doctor prescribed an iron and vitamin supplement for their anemia, but I cannot afford it so I give them SS Tonic which is cheaper. I pay about $34.00 each month for the pads, oil, soap, and tonic in addition to the $9.00 drug co-payments.

10. Wesley has to do without his special pads because the only place we can get them is at Crippled Children's Hospital in Mobile, and we cannot afford to drive the 100 miles, round trip. My druggist says the pads cannot be specially ordered. We also cannot afford to drive to Pennsecola to the skin specialist so that Terry can get a new prescription for his skin condition. He has been out of that medicine for several months. It costs $30.00 every two weeks.

11. Since my husband was injured, his only income has been about $60.00 a month doing odd jobs like cleaning yards. We own our home; but, as stated in an earlier affidavit, it was severely damaged by Hurricane Frederick and still needs much work. In addition to the above medical costs, our monthly expenses are:

a. Food in addition to food stamps--$100 (charged).

b. Gas--$55.00.

c. Electricity--$39.00.

d. Transportation--$130.00 (does not include repairs to our very old car).

e. We pay Goodyear $76 for the car repairs, washer, and stove.

f. Telephone--was disconnected because we owed $86.00.

g. We just re-financed $120.00 for furniture and we do not know yet what our monthly payment will be. We had to re-finance because we had missed so many payments to the furniture store.

h. We owe $98.00 to a doctor and pay $10.00 a month whenever we can. We also owe a hospital thousands of dollars from Wesley's accident. We have not bought clothes for a long time, and have relied on hand-me downs from family.

12. My children need their medicine in order to keep them alive. We have let bills go unpaid in order to get it for them. Now we have to pay higher co-payments. For example, Terry's skin medicine costs over $30 and must be bought every two weeks. There is no point in going to Pennsecola to get the new prescription because we do not have the money for the higher co-payment. I do not know how much longer we will be able to get the children's drugs. I am afraid we are going to have to cut down on the amount taken. I also am not sure how long Terry can go without his skin medicine.

Arlene Cheesebrew
ARLENE CHEESEBREW

Sworn to and subscribed before me this 2nd day of June, 1980.

Notary Public
NOTARY PUBLIC

AFFIDAVIT

STATE OF ALABAMA)
:
MADISON COUNTY)

Before me, the undersigned authority in and for said State and County, personally appeared this day MATTIE L. LACEY, who being first duly sworn, deposed and said as follows:

My name is Mattie L. Lacey and I live at 719 Orchard Street, N.W. in Huntsville, Alabama. I am 89 years old. My sole source of income is my Supplemental Security Income check for $208.20 each month, which also makes me eligible for Medicaid. I am not presently receiving Food Stamps, and must pay about $40.00 a week for a special diet my doctor, William Corley, M.D., of Huntsville, has prescribed for me.

My average utility bill is about $80.00 per month, and I pay $12.00 per month for my telephone and $21.00 per year for my fire insurance on my home. Also, some of the drugs Dr. Corley and my eye doctor, Dr. Moorman, have prescribed are not covered by Medicaid and I must pay for them myself, or rely on my daughter, Mrs. Georgia Lanier, to help me, as she already does on my bills.

I suffer from high blood pressure and a heart condition, as well as kidney problems and very poor eyesight. As a result of my medical conditions, including my special diet, I have to see my doctors at least once or twice a month. With my SSI check and all my bills, there is just no way I could possibly pay $2.00 every time I have to see my doctors; I would just have to not see them or do without my medicine or something else like my special diet.

Mattie L. Lacey (X)
MATTIE L. LACEY

Sworn to and subscribed before me this 8th day of April 1980.

Mary Jane Erskine
Notary Public

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PATRICE POTTER, et al.,	)	
Plaintiff,	)	
vs.	)	CIVIL ACTION NO. 80-0154-N
FOB JAMES, et al.,	)	
Defendants.	)	

AFFIDAVIT

STATE OF ALABAMA

COUNTY OF MONTGOMERY:

Before me the undersigned notary public in and for the State of Alabama personally appeared William Tellis who, being duly sworn, deposes and says:

1. I am 62 years old and live at Estes Health Care Center, 520 South Hull Street, Montgomery, Alabama. I have been a resident at Estes since July, 1975.

2. Before entering Estes Health Care Center I lived with a family friend who assisted me with all my personal needs. I paid her a portion of my disability benefits from my Supplemental Security Income (SSI) for taking care of me. The only time I worked was when I was a child when I lived on a farm and did chores.

3. I have not been able to walk for 44 years. This is as a result of severe ankylosing spondylitis (arthritis of the spine) and crippling rheumatism. I am also afflicted with esophagael dilitation for which I was operated on in August, 1979. Also I suffer from acholasia, an inability to swallow and have broncho-spasms from asthma.

4. I take the following medications on a regular basis:

a. Indomethacin 3 times a day for my arthritis;

b. Brethine, a broncho-dilator 4 times a day for my asthma;

c. Theodur twice a day to help me breath;

d. Metamucil at bed-time as a laxative;

e. Maalox as needed for acid indigestion;

f. Nutraderm lotion to lubricate my skin and avoid bed sores.

In the past three months I have also paid for the following medications:

a. PhisoHex and Cortisporin ointment for a bad rash; PV Tussin, a cough medicine and Histelet Forte a decongestant for a bad cold.

5. Three of my regular medications are covered by Medicaid so that I need only pay a 50¢ co-payment each time I receive each one. The other medications are not covered by Medicaid and cost approximately $10.00 a month.

6. Over the years I have saved a small amount of money from birthday and Christmas presents from my brother and sister. Until recently these small savings, in my personal fund account at Estes were withdrawn by Estes to pay my prescription drug bill at Geriatrics, (the separate corporation which runs the in-house pharmacy at all the Estes Health Care Centers). I owe Geriatrics, Inc., a balance of $243.67. They assess a finance charge to me at the annual rate of 18% also.

7. Two of the drugs paid by Medicaid, Indomethecin and Brethine cost more than $12.00 each. From what I have been told, I will have to pay 50¢ more each month for each of these drugs.

8. I am also assessed a personal laundry charge of $45.00 a month. Estes takes my $25.00 personal needs allowance check from Social Security and writes off the rest as uncollectible.

9. I cannot afford to pay more out of my small monthly income for drugs, as this entire income goes toward the cost of my personal laundry at Estes. My tiny savings are reserved for such essentials as new pajamas, hair cuts, and an occasional book. As it is now, I cannot get all the things I should have.

10. I never received any word from the Medical Services Administration that I might be able to have a fair hearing to try to resist paying any more of my limited income for the cost of my prescriptions.

11. I am participating in this lawsuit to try to keep my drug bill from getting so high that I could not afford all the drugs I need to take.

William Tellis
WILLIAM TELLIS

Sworn to before me this 16 day of May, 1980.

_____

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PATRICE POTTER, et al., $
Plaintiff, $
vs. $ CIVIL ACTION NO.: 80-0154-N
FOB JAMES, et al., $
Defendants. $

AFFIDAVIT- SUPPLEMENTAL

STATE OF ALABAMA)
COUNTY OF MONTGOMERY)

Before me the undersigned notary public in and for the State of Alabama personally appeared WILLIAM TELLIS who, being duly sworn, deposes and says:

1. I am 62 years old and live at Estes Health Care Center in Montgomery, Alabama. I wish to add the following information to my earlier affidavit.

2. The $25.00 I receive from Supplemental Security Income (SSI) as a personal needs allowance goes to pay the $45.00 monthly laundry charge.

3. I have to rely on very small gifts ($2.00-$3.00) from my relatives at holidays in order to pay for my personal needs. Because these gifts are very small and only come at times like Christmas, Easter, and my birthday, I am unable to buy all of the things I need.

4. My largest expense is clothing. I wear undershorts and shirts every day. I also need to have several pairs of cotton socks for the few times I am able to get out of bed and sit in a wheelchair. Undershorts cost me about $10.00 for 3 pairs and I have to buy these about 3 times a year. The cheapest shirts I can find cost at least $5.00 each and I can only afford to buy 6 a year. Not only do my clothes wear out from frequent washings, but some are lost at the laundry. In order to have clothes, I am unable to buy other things I want and need.

5. I need a haircut about twice a month, but I usually have to go longer between cuts. A friend comes to Estes to cut it for me at no charge, but I give him $2.00 or $3.00 for gasoline. This is much cheaper for me than if I had to pay a barber.

6. My eyes are pretty weak from the cateract surgery I had four years ago, so I am unable to read very much; but I do read the Bible when I can. My cousin pays $11.00 each month for the telephone in my room. The telephone is my major source of entertainment and contact with the outside. I cannot afford to make any long distance calls.

7. I write a few letters to my family and friends each month. The envelopes and composition paper cost about $.75, and I buy them twice a month. I also buy about 5 stamps at $.75.

8. I send out for snacks, such as candy bars, about 4 times a month. Each candy bar costs me $.30. I buy batteries for my radio every one and one-half months. Batteries cost about $5.00.

9. Estes provides me with toothpaste and Listerine. I have to buy after-shave lotion and cream for pimples. As these items cost several dollars, I try to use them sparingly in order to make them last. I also have to buy cotton handkerchiefs which cost about $1.00 for 3.

10. I have no money for anything additional. My drug co-payments are being billed to me by Geriatrics. I owed Geriatrics $281.98 as of May 23, 1980. I know that at least two of my drugs will have a co-pay of $1.00 each now. This higher co-payment, along with the lotions and drugs not covered by Medicaid, will make my bill higher. I do not know for how much or for how long Geriatrics will bill me.

William Tellis

WILLIAM TELLIS

Sworn to before me this 1 day of July, 1980.

Robert Wayne Cobb

NOTARY PUBLIC

My commission expires: 12/11/82.

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA

PATRICE POTTER, et al.,	*	
Plaintiffs,	*	
	*	CIVIL ACTION NO.
V.	*	
	*	AFFIDAVIT
FOB JAMES, et al.,	*	
Defendants.	*	

STATE OF ALABAMA *
SS:
COUNTY OF PERRY *

Before me the undersigned Notary Public in and for the State of Alabama personally appeared Jessie Williams who, being duly sworn, deposes and says:

1. I am 81 years old and live at the Southland Nursing Home in Marion, Alabama. Except for the time I have spent in the hospital and the short time three years ago when I tried to take care of myself, I have lived at Southland Nursing Home for the past six months.

2. After having worked most of my life, I am no longer able to work. In fact, I can hardly do anything for myself, although I very much want to. I cannot stand for long. I can only walk very slowly and very carefully; and if I walk far, I give out in the chest and have trouble breathing.

3. I have very bad arthritis, severe anemia, a blood disease called multiple myeloma, and a bad heart. I have been hospitalized several times, mostly for my blood problems.

4. I take the following medicines regularly:

a. Dioxin four times a day for my heart;
b. Mylanta five times a day for my stomach;
c. Tylenol five times a day for arthritis pain;
d. Dyazide capsules daily for blood pressure;
e. Cyclospasmol capsules twice a day to reduce swelling;
f. Serapes daily for blood pressure;
g. Trinsicon three times a day for iron;
h. Noctec dran daily so I can sleep.

6. Four of my medicines are covered by Medicaid, so that they cost me 50 cents each time I get each one. The other four are not covered by Medicaid and cost over $60 a month. My sister, Adeline

Stewart, has been paying this amount; but she only gets a small Social Security check herself, so she has to do without some of her own drugs to buy mine.

7. Two of the drugs paid by Medicaid, dyazide and serapes, cost more than twelve dollars each. For what I have been told, I will have to pay 50 cents more each month for each of these drugs.

8. I also have to pay laundry charges of $45.00 a month. The nursing home takes my $25.00 check and gets the rest from Adeline Stewart.

9. Neither my sister nor I can afford to pay more out of our small incomes for drugs. As it is now, I cannot get all the things I should have.

10. I recently received from the Medical Services Administration a notice that said that Medicaid recepients shall pay the "maximum copay" for drugs except family planning and "EPSDT drugs." I do not know what EPSDT drugs are. The notice did not say how I might challenge this change.

11. I am taking part in this suit to try to keep my drug bill from getting so high that I could not afford all the drugs I need.

Jessie Williams
JESSIE WILLIAMS

Sworn to before me this 16th day of May, 1980.

Betty Clary
NOTARY PUBLIC

My commission expires: 1983.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PATRICE POTTER, et. al.,	*	
	*	
Plaintiff,	*	CIVIL ACTION NO.
	*	80-0154-N
v.	*	
	*	INJUNCTIVE RELIEF REQUESTED
FOB JAMES, et. al.,	*	
	*	
Defendants.	*	

STATE OF ALABAMA *
*
COUNTY OF PERRY *

SUPPLEMENTAL AFFIDAVIT

I, Jessie Williams, being duly sworn, do hereby depose and say:

1. I am 81 years old and live at the Southland Nursing Home in Marion, Alabama.

2. Before going into the nursing home I received benefits from the Social Security Administration and the Veteran's Administration. I have been told that approximately $140.00 of these benefits are still being paid, but that all but $25.00 of this money is going to pay part of the basic cost of my care at the Southland Nursing Home.

3. None of these benefit checks is being used for the required copayments on my Medicaid drugs or for the cost of my drugs that are not covered by Medicaid. As shown by my first affidavit, Adeline Stewart, who is my sister and nursing home sponsor, must pay for these drug costs herself.

4. As I understand it, the $25.00 that is held out from my benefit checks is totally consumed in paying for my laundry expenses at the nursing home.

5. In addition to paying for my drug bills that are not covered by Medicaid, my sister, Adeline Stewart, must also pay for my personal clothing which costs her between

$75.00 and $100.00 per year; fresh fruit which I eat for snacks which costs her about $2.00 per month; my personal grooming aids which cost her about $10.00 per month; and for having my hair done which costs her about $5.00 every other month.

6. I know that my sister does not have very much money and that she has to do without seeing her doctor and without receiving all of her medication in order to pay for all of my costs. I also believe that my brother, James Price, needs to be a nursing home too, however, my sister cannot afford the cost of sponsoring both of us in a nursing home at the same time. I wish that I could use my benefit checks to pay for my own drug expenses that are not covered by Medicaid and for my other personal expenses, because my sister would then have the money to properly care for her own health and sponsor my brother's nursing home care.

7. Neither the nursing home administration staff nor the Medical Services Administration has ever told me that Federal Medicaid law permits me to keep a portion of my monthly benefit checks above and beyond my $25.00 personal needs allowance to pay for any medical or remedial expenses not paid by Medicaid.

Jessie L. Williams
JESSIE WILLIAMS

SWORN and SUBSCRIBED to before me this 3rd day of July, 1980.

Betty Clary
NOTARY PUBLIC

My Commission Expires: 1982

STATE OF ALABAMA I
LAUDERDALE COUNTY I

AFFIDAVIT OF JUDIE JONES

Before me, the undersigned authority in said State and County, personally appeared Judie Jones who, after being duly sworn, deposes and says as follows:

My name is Judie Jones. I am a plaintiff in this case challenging the increase in co-payments for Medicaid covered drugs. I received a notice dated on or about May 5 from Medical Services Administration that the co-payment for the drugs I take would be increased from $.50 to $.50, $1.00, $2.00 or $3.00 based on cost. The notice said that it was in accordance with Act 80-155 of the 1980 Alabama Legislature.

I live at Route 2, Box 216-C, Florence, Alabama 35630. I have three daughters, age 15, 14 and 10. The father does not live in the home. My only income is $148.00 per month from the Aid to Dependent Children program and $207.00 per month for food stamps. I pay $41.00 per month for a house and $23.81 per month for housing insurance. My telephone costs $15.00 per month. I need it to call Birmingham, where I must go regularly for medical treatment for my diabetes. My utility bill is approximately $60.00 per month in the summer and over $100.00 per month in the winter.

I must go to Birmingham once a month and sometimes once every two weeks because of my diabetic condition. My father is no longer earning any money and cannot provide the transportation. I do not drive, nor do I have a car. The bus costs $23 round trip each time I go.

Because of the ADC program, I am presently receiving Medicaid benefits for myself and my children. My oldest daughter, Alice, age 15 suffers from black-out spells and is presently requiring some extra medical attention.

I must take five drugs regularly, four of which are covered by Medicaid. I take Dyazide for my high blood pressure. I get 60 day supplies at the K-Mart Pharmacy in Florence. To the best of my knowledge, this 60 day supply costs $7.13. I take Zyloprim for a problem with my uric acid. I also get this in 60 day supplies from the K-Mart Pharmacy in Florence. To the best of my knowledge, this costs $13.96 for 60 days. I take this once a day in a 300 miligram tablet. For my diabetes, I must mix two types of insulin. The NPH, No. 449510, to the best of my knowledge, costs $4.35 for a 45 day supply. The regular insulin, also called U-100, No. 449507, to the best of my knowledge, costs $4.35 for a 45 day supply. This money is what Medicaid pays K-Mart, to the best of my understanding, for providing me these drugs. At present, I pay $.50 each time I get one of these prescriptions filled.

I am very concerned about the notice that the co-payments would be higher. With my own heavy medical costs, not only in terms of actual service, but also transportation, and the costs of living expenses for my three children, I cannot afford these increased costs.

My budget is so tight that a few months ago I was forced to go without my insulin for a brief period because I could not afford to pay for syringes. That is how tight my budget is. I don't really understand what the notice says except that it means that I am going to have to come up with more money in order to obtain the medicines I need just to survive.

Judie Jones

Sworn and subscribed to before me this ___ day of May, 1980.

Notary Public

Mr. WAXMAN. Thank you for your testimony. Both you and Ms. Waxman referred to some documents you wanted to have submitted for the record. They will be received by the committee and put in the record at the discretion of the chairman.

I would like to now recognize Mildred Brown who has accompanied you from Alabama. Do you have a statement?

STATEMENT OF MILDRED BROWN

Ms. BROWN. Yes, I do.

My name is Mildred Brown and I am 67 years old. I have been a resident of Alabama all of my life.

My income consists of $172 per month from my deceased husband's retirement pension and $133 per month social security. My State supplement check which entitled me to medicaid was terminated in April because I received a raise on my pension check. I requested a hearing on the termination and as a result my medicaid was reinstated because an error was made in computing the budget. Because I had no medicaid in April and May, I was forced to do without medication, thus the reason my condition is more severe at the present time.

My utility bills are extremely high because I have to have air conditioning for asthma and I must have a telephone to call my doctor or an ambulance. In addition, I have other utility bills, a mortgage payment, drugstore bills for medication not covered by medicaid, and I have to pay for home nursing care because I am unable to do any housework and need help preparing my meals. I also have to spend a great deal of money for taxi fare to and from the doctor and drugstore.

I suffer from osteoarthritis, rheumatoid arthritis, bad nerves, spastic stomach, kidney stones, no vision in one eye, loss of hearing, and hardening of the arteries. One of my five doctors does not accept medicaid and two of the others have only been accepting it for a short while.

Because of my conditions, I can only eat certain foods. I receive $56 per month in food stamps, but they don't go very far when you are on a special diet. Because of my high utility bills, and all of my other expenses, I never have any money left. When Ms. Bennett asked me when I had last bought any new clothes or shoes, I didn't know whether to laugh or cry, because it's been so long since I could afford to do that. Any increase in copayments would be disastrous for me because I don't have enough money now to make ends meet. Any additional expenses would cause me to do without certain necessities, such as my air conditioner or my home health care.

Mr. WAXMAN. Thank you very much. We appreciate your coming here to give us your views on this.

Mr. Gordon.

STATEMENT OF SPIVER W. GORDON

Mr. GORDON. Mr. Chairman, Mr. Shelby, I would like to thank you for the opportunity to be here this afternoon. Let me preface my remarks by saying that I am not an expert in medicaid and I don't have any real answers as to the solutions to this very com-

plex problem, and I certainly don't know how to bridge the gap between the concern of Mr. Gramm this morning when he talked about getting those who have and those who have not in it both pulling together.

I do recognize, and I guess I submit basically to my early Sunday school training, which says that the strong shall bear the infirmities of the weak, and I know that through God's will all things are possible, and I would submit that this body should give some very serious consideration to this very complex problem and the solution in my opinion is not adding additional burdens to poor people.

Mr. Chairman, members of the subcommittee, my name is Spiver W. Gordon of Eutaw, Ala. I am president of the Green County Southern Christian Leadership Conference, State vice president of the Southern Christian Leadership Conferernce, and national board member of the Southern Christian Leadership Conference. In those connections I work directly with the poor and dispossessed in the State of Alabama and most specifically west Alabama in the black belt.

I am here today to ask this honorable chairman and subcommittee to not place any additional burdens and hardships upon the poor people of Alabama by passing this very bad piece of legislation that would amend the Social Security Act allowing the States to add copayments.

As most of you may already know, the medicaid program in the State of Alabama is currently undergoing a crisis situation due to a shortage of funds and an unwillingness on the part of the State legislature to adequately fund this much-needed program.

This crisis has created serious problems for poor people in the State of Alabama and more particularly in the very poor counties of west Alabama. This region of the country is extremely poor. Green County, my home county, is the Nation's fifth poorest. Hale County and adjoining county has the highest unemployment rate in the State of Alabama. AFDC recipients throughout Alabama receive only $148 per month for a family of four which comes to $1,800 a year. At present, families with an income of $2,000 or less already spend 12 percent of their income on medical care.

Copayments would obviously force these families to choose between medical care and other absolute necessities.

In addition to the serious problems this crisis has created for all poor people, minority poor people are particularly hard hit. In 1979, the white beneficiaries who constitute one-third of the medicaid population in Alabama received 60 percent of all medicaid payments in the State.

If you look at Green County, my home county, which has one of the highest percentages of nonwhite populations in the State, you will find that it also has one of the lowest total payments of medicaid in the State and the lowest expenditure per eligible recipient in the State. In general, across Alabama you will find that the counties with the higher percentages of minority citizens have lower medicaid payments.

Copayments would have a disproportionate effect on minorities for a variety of reasons. First, medicaid statistics show that minorities use more outpatient services, for example, than whites who

use more nursing homes. Because of the type of service minorities use, copayments therefore would fall more heavily on them.

Also, of categorical assistance eligibles, AFDC-related recipients are disproportionately minority while of SSI-related recipients more are white. The SSI recipients have a more adequate income than AFDC recipients. The burden of copayments would clearly be more difficult to meet by the predominately minority AFDC recipients.

Another effect of copayments is that it deters individuals from seeking necessary doctor visits. Usually it is the first visit to a physician that is deterred since subsequent visits are dictated by the physician. Copayments will have the effect of increasing the number of people who never see a doctor. Because minorities need more doctor visits, the number of minorities who never see a doctor will be increased if copayments are used.

Copayments will also adversely affect physicians participation in the medicaid program. Physician participation is a particularly severe problem in rural areas such as parts of Alabama. It can be especially drastic in a medically underserved area. By forcing doctors to collect copayments from patients, more physicians are likely to drop out of the program. In an area where few doctors serve minorities presently, a copayment system which results in fewer participating physicians would be devastating.

Mr. Chairman and members of this subcommittee, this proposed piece of legislation would again place an unnecessary, unfair, and disproportionate share of the responsibility on the poor people and particularly poor minority people who are already witnessing financial depression in this country.

I urge you today to go on record opposing this piece of legislation and say so to the countless number of persons across the length and breadth of this State and country who simply cannot afford any additional burdens to carry.

I thank you very kindly for your attention and consideration.

Mr. SHELBY [presiding]. Thank you, Mr. Gordon.

Ms. Hamburger?

STATEMENT OF BETTY K. HAMBURGER

Ms. HAMBURGER. My name is Betty Hamburger and I am a resident of Baltimore living at 101 Brightside Avenue. I represent the National Citizens' Coalition for Nursing Home Reform, a nonprofit organization representing 78 citizen groups throughout the country and 300 individual members. We thank you for the opportunity of expressing the consumer point of view and that is me. I am one of the ones you were talking about before who is getting all the benefits—the consumer point of view on H.R. 7028—though we strongly oppose the enactment of this bill.

H.R. 7028 appears to aim to reduce public medicaid expenditures for nursing home care by encouraging relatives of the institutionalized to make voluntary contributions to a State long-term care fund. We find this concept questionable on many counts. The major question is whether these contributions are genuinely voluntary. Is this fund designed to provide care and services to those eligible for medicaid services, or only for those with relatives who can contribute?

We realize the financial problems in medicaid and the growing costs, but these problems should be alleviated by other means than by asking the poor and their families who are getting something like $148 a month to live on, asking them to contribute. We suggest that you look at the providers of care and examine their records and see if you cannot save some money in that area.

We are afraid that the words "may contribute" will become a "must contribute" position. This seems untenable to us and in complete contradiction to the basic philosophy of the Social Security Act, titles XVIII and XII. Will voluntary contributions establish a class system which differentiates in the amount of care provided to residents whose families contribute and those without family contributions? What services will be paid for by these contributions? What important services will no longer be extended to those without extra family support?

We heard this morning something about a third level of care. Poor people, we would gather from that, would get a lower level of care than those whose families could contribute.

Families are already contributing to the medicaid funds through payment of taxes. Do we require double taxation for State services? Take the public school system, for example. Should we be prepared to enact special legislation encouraging all families whose children actually attend public schools to make voluntary contributions to a special educational fund for the provision of educational assistance?

Conversely, we do not allow those who, in a given period, do not have children in a public education institution to have the right to opt out of paying taxes to support the school system because we have accepted a community responsibility to provide for those children. We have accepted that same responsibility for our Nation's elderly. We olders do have co-pay in medicare. You may know that before you can get any benefit, you have to spend $60 of your own money. I cannot tell you how many people in Maryland do not go to a doctor when they first observe symptoms because they do not have $60 to pay. This is a situation that I am sure would be repeated many times in the State of Alabama. I use it as an example of what co-pay does to people.

There is nothing in the medicaid statutes that prevents anyone from making voluntary contributions to nursing homes or to any governmental agency. Many people make such contributions to public or semigovernmental agencies such as schools, universities, museums, hospitals, and nursing homes. That is entirely different from mandating such contributions. If contributions are to be genuinely voluntary, then you don't need any legislation because it is already on the books, and new legislation makes a mockery of the word "voluntary."

Under most accepted interpretations, medicaid assistance is available to any needy person when in need of treatment in a hospital or nursing home without regard to race or color. Need or inability to pay is the sole criterion. H.R. 7028 seeks to make family responsibility an additional criterion.

Another point to remember is that families of medicaid patients, and this has been brought out in the last testimony, living close to the nursing home, often have little or no money and are often on

welfare themselves. Saying relatives may contribute when we realize they can't afford to is just another way of keeping poor patients out of nursing homes. This will hit minority patients very hard.

Furthermore, few patients have families in the area. In fact, nationally over 50 percent of residents in nursing homes have no families. Alabama must be different if there are. According to figures given this morning, 80 percent have families nearby who could afford to contribute. At least that was the figure I heard this morning.

In point of fact, families do take care of their frail elderly. Generally elderly persons do not go into nursing homes unless they are so severely impaired that their families can no longer care for them or their families cannot support them any longer, or most likely of all they have outlived their families. How can poor, often nonexistent families contribute to those in nursing homes?

Families do provide care and financial support as long as they are able to. Patients entering nursing homes with any resources of their own do not qualify for medical assistance and they must pay for their care.

Frequently, this is a family contribution until the family can no longer afford to pay. In many States, before a patient can be accepted in a nursing home he or his family must agree to pay as a private patient for specified periods of time, from 1 to 3 years.

Even in the State of Maryland, which we regard as being very advanced, we just managed to get a bill through the State legislature that provided that patients going on medicaid could not be considered not paying for reasons of transfer after a year of having been private pay patients, so you see that this exists all over.

I know personally of the case of an 86-year-old woman who said she could pay for herself for 2 or 3 years. The nursing home would not take her unless her grandnephew, the only relative, would accept full fiscal responsibility for her for at least a 3-year period. The young man was financially unable to do this so the old lady never got into the home. She died a few months later.

While a spouse is supposed to contribute to a patient's support, he must not impoverish himself doing so. This is a bill that came before Congress last year. Children, grandchildren, or siblings are not obligated.

Last, we understand Alabama already has a provision requiring any person admitted to a nursing home to have a sponsor. A sponsor must agree to pay an average of $45 per month—I understand it is as high as $200—to have the patient's personal laundry done. This is a high price to pay for washing a few nightgowns or pajamas, robes, blouses, or shirts. Enforcing this sponsorship and refusing to accept medicaid patients without a sponsor is a rank example of discrimination against the poor. Frankly, we are afraid that a poor person will not be able to get into a nursing home unless he has a sponsor.

What is the sponsor's money going to be responsible for? Will that resident be able to retain his personal allowance to cover the many other extra expenses, or what happens to the $25 that he is supposed to have as personal allowance?

We also do not feel that nursing homes which are recommended by Merrill Lynch as the best investment should make a profit at

the expense of the rest of us who are paying for this service, and we think that one of the big items in the cost of long-term care is the profits made by nursing homes. And we call this to your attention again, if you want to economize, try to go after the profits made by doctors and the laboratory technicians.

We are more unhappy over the increasing costs of medical care than you are. But penalizing those who can least afford such care is not the way to cut costs. We must instead provide more services to help families care for their frail elderly at home. Many more families would keep their frail elderly relatives at home if they could get respite care 1 night a week and 2 weeks in the summer.

We made the survey to prove this and we were amazed at how many people themselves in their seventies and eighties are taking care of their elderly relatives. This is particularly true in minority groups, and all they ask is could we just have 1 night a week where we could go out by ourselves? Could we just have 2 weeks in the summer? This is the kind of service that we mean.

We could also have homemakers, for example, for a few hours per week. This would keep more people at home. Sheltered housing provides another vehicle, but I am not going to tell you very intelligent gentlemen how to save money on medicaid costs. I am sure if you put your minds to it, you could find very many better ways to do it rather than to take it out of the hides of the poor.

We urge you to defeat H.R. 7028 which would eventually make voluntary contributions obligatory. It would contravene the intent of Congress in the medicare and medicaid bills to relieve the burden of ill health for the old and the poor. Let us not make nursing homes the last resting place for the rich only. Unhappily, they are an ultimate necessity for many of us. I ought to know since I am 76.

I look with dread upon having to go into a nursing home. Justice, not charity, is what most of us want.

Thank you, gentlemen, for listening to me, and lady, and I certainly appreciate the opportunity.

Mr. SHELBY. Thank you, and I appreciate the panel being here. I would like to address one question to the panel, and it would have to do with the fraud on the recipient.

I know we have fraud by the provider. I have dealt with it on a State basis back home, Mr. Gordon, as you know, and it has been prevalent in a lot of areas and I think that we as Members of Congress need to be also mindful of it, not just the recipient but the provider, too.

I think where you do have fraud in the recipient, and that is what we are talking about right now, that we ought to have a method to deal with it.

One of them is administrative termination of fraudulent recipients. You have administrative hearings on just about everything else, administrative hearings on social security, whether or not you are going to receive it to begin with, whether or not it is going to be terminated, on disability and everything.

You have administrative stuff rather than just court. You have an ultimate appeal on the social security hearing to a Federal district court only for review, not a real hearing as such.

I was wondering if any of you had thought about this administrative review to terminate someone where the recipient had abused to the point of fraud the medicaid situation.

One thing that I have thought about, with the aid of some members of my staff, we might want to change the evidentiary standard to substantial evidence, which is really a lesser standard. It is usually used in administrative proceedings. That is something we can talk about here.

What I am getting at. I know you all are not in the legislative arena. You are dealing with it in one aspect, all of you are. I think we have to start out that most of us are interested in providing, as Mr. Gordon says, for the weak, the people who can't help themselves. I think we are. I know I want to, but from the standpoint of legislation, I think we are going to come, whether you are in the State of Alabama, the State of California, the Federal Government itself, what kind of restraints are we going to have?

No one wants to deny someone who needs medical aid—I say no one. You have seen where people didn't want to treat them if they didn't have the money, and I think that is wrong. But I certainly don't want to say to someone that needs medical help, whether they are old or young, whether able bodied and young or they are handicapped, that we are not going to help them, but I think there is some need for improvement in the administration of medicaid, not only in Alabama but across the country, and there are some cost savings there.

But in doing this, let's not hurt the people that we really want to help. Do you have any thoughts on how you would deal with fraud in the medicaid recipient program?

Ms. WAXMAN. If I may, Mr. Shelby, I would like to answer that. Let me say from the outset that we, too, of course, are opposed to fraud in any form in any program.

Mr. SHELBY. Sure.

Ms. WAXMAN. The problem that we see——

Mr. SHELBY. Whether it is the recipient or the provider.

Ms. WAXMAN. Of course, either way. The problem that we see with the proposed legislation is that, it proposes that findings of fraud be made in an administrative hearing and I have doubts that I have expressed about that, but even more importantly it is the standard of proof that we are concerned about. This is a criminal charge in which someone is being accused of willfully and knowingly making false statements and misrepresentations, and therefore we think that it is the "beyond a reasonable doubt" standard that should apply hold for that kind of accusation.

There isn't any reason to lower the standard of proof. If the person is actually being accused of committing a fraudulent act then certainly he or she deserves the protections that we have given in all criminal proceedings in the past.

Mr. SHELBY. What other suggestions are there short of that? Do you have any other ideas how you could terminate abuse of the program?

Ms. WAXMAN. I really don't have any new suggestions except to say that I am not sure how many people actually have been brought to trial for criminal acts. If the State finds that it has

enough evidence to bring the individual to trial, certainly we are not opposed to that.

Mr. SHELBY. Do you know or would you think that there would be a lot of abuse in the program nationwide? Let's not just talk about Alabama.

Ms. WAXMAN. My guess is that there would be more abuse on behalf of the providers, and this is actually supported by what Ms. Bennett has found in Alabama. The figures she quoted in her testimony came from the State agency itself. The figures showed, if I may read this, that during the 10 months ending March 22, 1979 the medical services administration had identified almost $600,000 to be recovered for fraud and abuse. From recipients, $34,000 was identified which was 5 percent of the total and from providers $566,000 was identified or 95 percent.

Mr. SHELBY. Thank you.

Mr. Dannemeyer?

Mr. DANNEMEYER. I would like to ask a question. I missed the presentation of most of the members of this panel, Mr. Chairman, but I did hear some comments from Mrs. Hamburger and I would like to ask just a couple of questions.

My mother is in a rest home in California, in Fullerton, my hometown, and has been there for some time. Over the past couple of years, I had occasion to look around for a new facility because a change was needed. In doing that I ran across a facility where there was the wife, a widow of a doctor working there part time, and in looking over the facility I talked with her about such things as accommodations, services, and price, and I don't think she was aware that I was in the business of being a legislator and she just volunteered to me some things.

She said, "Well, what you ought to do is this. Does your mother have any assets?"

I made clear that I would be responsible for her care.

She said, "Well, you know, you should do what some of the children of the people in this home do."

I said, "What is that", with interest.

She said, "Well, if the parents have any assets, they just transfer them to the kids so that the parents have nothing and then they are eligible for medicaid."

I said, "Oh."

She said, "Yes, there are a number of doctors who serve patients in this facility whose mothers are in this facility, and their care is being paid for by the taxpayers of California and the United States."

Those doctors will remain nameless for obvious reasons, but I don't think that those doctors are in what you would call an economically disadvantaged neighborhood or income bracket.

Do you think it is right for our system to permit those doctors to have their mothers in a rest home cared for by taxpayers when they are obviously financially able to bear that privilege themselves?

Ms. HAMBURGER. Would you call that provider fraud? I would.

Mr. DANNEMEYER. I don't say it is fraud. It is perfectly legal.

Ms. HAMBURGER. But this question came up.

Mr. DANNEMEYER. It is perfectly legal, because our system does not require the relatives to be responsible for the care of their patients.

Ms. HAMBURGER. No, not parents, just spouses.

Mr. DANNEMEYER. Do you think it is right that our system will permit a child to be relieved of the responsibility of caring for their own parent when they are financially able to do it?

Ms. HAMBURGER. I want to tell you something. I am a God fearing woman, sir, and if a person is a religious person and believes in the Commandment "Honor thy father and thy mother," it won't happen. This is somebody that has no moral sense, and I don't think you can legislate for people who have no moral sense.

Mr. DANNEMEYER. Wait just a minute now.

Ms. HAMBURGER. By the way, sir, I am a native Californian.

Mr. DANNEMEYER. We can pass a law, if we have the political will to do it, which will require the children of a parent to be responsible for the care of that parent to the extent that they are able to do it. We used to do this years ago.

Ms. HAMBURGER. I know you did.

Mr. DANNEMEYER. And we got rid of it ostensibly because, it is not right to ask children to be responsible for their parents, but my friend, we have got to do something. We can't continue to sit here in the face of spiraling medical costs and just pretend that, well, there is nothing we can do.

Ms. HAMBURGER. We have given you some suggestions. If you look to the cost of providers and the amount of money that the doctors are making, and the amount of money that the nursing homes are making, and the amount of money that the technical laboratories are making, you could really save a bit of money. That is where your fraud abuse is.

Mr. DANNEMEYER. Let's analyze that. There is no legislator around who is going to be able to repeal the law of supply and demand. There will be some running for public office who will claim they can repeal it, but you just can't do it. You can't repeal human nature. Our political system has placed such a load on the medical care delivery system of this country that the providers are in the position of being able to charge just about what they want to.

Now, the answer is not, in my opinion, to go ahead and put regulations on the medical care providers and create another bureaucracy to police them. That is not the answer. The answer is to attach to those who have need for the services a portion of the responsibility for paying for them, because my assessment of human nature is such that if the person getting the services must be personally responsible for a portion of the cost, he or she will be less the provision of those services.

Ms. HAMBURGER. Many of us at the present time, do have to pay for the services, sir, because if we have no money whatsoever, no assets, we have used up whatever we have before we go on welfare. Believe me, medicaid and welfare are anathema to most people, they hate it.

This business of holding out your hand and begging is the thing that most of us hate the most. We don't do it unless we absolutely have to. And I can see that the time may come with nursing home

costs and medical costs going up, as they are, that I might be able to pay for myself in a nursing home for a certain number of years, and if I am still alive, God forbid, I am going to have to put my hand out and say to medicaid, please pay for me.

I don't look forward to it with any pleasure. I don't think there are any people who do look forward to taking charity as such. Medicare is different. Medicaid is putting out your hand and asking for help, and it is a humiliation to do it.

Mr. DANNEMEYER. I understand. Thank you very much.

Mr. SHELBY. I appreciate all of you appearing here today.

Mr. EDELMAN. I had submitted prepared testimony on H.R. 7028.

Mr. SHELBY. That will be part of the record.

[Testimony resumes on p. 179.]

[The testimony referred to follows:]

Testimony of
Toby S. Edelman
before the
Subcommittee on Health and the Environment
House Committee on Interstate and Foreign Commerce

My name is Toby S. Edelman. I am a staff attorney in the Washington D.C. office of the National Senior Citizens Law Center and a member of the Board of Directors of the National Citizens' Coalition for Nursing Home Reform.

The National Senior Citizens Law Center is a legal service support center with offices in Los Angeles, California and Washington, D.C. We are funded by the Legal Services Corporation and the Administration on Aging to provide support and assistance to legal services attorneys and other advocates in the representation of their elderly and elderly poor clients.

My area of specialization at the Law Center is nursing homes. I am virtually in daily contact with legal services attorneys, advocates from the aging network, community advocacy groups and others concerned with nursing home issues and reform.

We would like to thank the Committee for the invitation to testify on H.R. 7028. We are, however, very troubled by the bill and strongly oppose its enactment.

H.R. 7028 would amend Title XIX of the Social Security Act (Medical Assistance) to allow states to establish programs for collecting voluntary contributions from the relatives of nursing home residents. No bill is needed to accomplish this purpose. There is nothing in the current Medicaid statute that prevents the relatives of nursing home residents (or anyone else) from voluntarily contributing to state government. Anyone who chooses to do so can already contribute to state or federal governments to support the Medicaid nursing home program or any other purpose.

Myths in H.R. 7028

H.R. 7028, however, apparently seeks to incorporate the concept of relative responsibility into the federal Medicaid program.[1] This attempt is based upon and reinforces a number of myths about nursing home residents and their families.

The first myth is that residents have relatives. Many do not. National data indicate that more than 50% of all nursing home residents have no close relatives at all,[2] many having outlived their families and friends. Older persons are often placed in nursing homes not because their families have "dumped" them but because they have no families to help care for them.

A second related myth underlying H.R. 7028 is that those elderly persons who do have families do not receive support from them. Again, the facts appear to be otherwise. Elderly disabled people who have families are provided a substantial amount of care and financial support by those families.[3] Generally elderly persons do not go into institutions unless they become very severely impaired (so that their families can no longer provide the necessary care) or until they outlive their family members. Families do provide a significant amount of support and assistance to their elderly members.

A third myth is that relatives of nursing home residents do not provide financial support to their institutionalized relatives once they are institutionalized. Once again the facts suggest otherwise. Nursing home care is generally paid for either by Medicaid or private payment, Medicare and

private insurance contributing very little.[4/] If persons needing nursing home care do not qualify financially for Medical Assistance when they enter nursing homes, they must pay for their care from their own and their families' financial resources. Some Medicaid-participating facilities require that residents pay privately for specified periods of time before the facilities will accept Medicaid payments on their behalf. Again, residents and their families contribute their own resources for the cost of institutional care. While the extent of relatives' contributions is not specifically known, these contributions do not appear to be inconsiderable.

Problems raised by H.R. 7028

In addition to being based on incorrect assumptions about current relative contributions to care, H.R. 7028 raises many serious questions which the bill fails to address.

1. How would relatives of nursing home residents be made aware of the existence of the fund and of their opportunity to make voluntary contributions? If the state communicated with relatives directly, either by phone or mail, relatives would reasonably believe that contributions were compulsory, rather than voluntary. How would the voluntary nature of the program be effectively communicated?

The issue of voluntariness is an extremely significant one. In 1977, recognizing that relatives of institutionalized elderly persons had been coerced into making "voluntary" contributions for care, Congress enacted section 4 of Public Law 95-142, the

Medicare-Medicaid Anti-Fraud and Abuse Amendments, 42 U.S.C. §1396h(d). This provision makes it a felony for a long-term care facility to charge, solicit, accept or receive "any gift, money, donation or other consideration" either as a condition of admitting a Medicaid recipient to the facility or as a requirement for the resident's continued stay.

Contributions to a state fund may be no less coerced than those directly demanded by a facility. H.R. 7028 contains no provision guaranteeing the anonymity of donors. Nor does it prohibit the Medicaid agency, which makes medical eligibility determinations for prospective residents, from learning whose relatives contributed to the state fund. The state agency could take into consideration whether contributions had been made on a person's behalf when deciding whether the person needed nursing home care. At the very least, relatives could reasonably be fearful that their contributions -- or lack of contributions -- would affect nursing home eligibility determinations.

2. Which relatives would be included in the voluntary donor category? Are grandchildren, cousins, nieces, nephews, and other members of extended families all considered prospective donors? What about relatives who live outside the state of the nursing home resident? How will residents' and their relatives' privacy interests be protected?

3. How would the funds be administered? Would relatives who contribute be able to earmark their contributions to provide certain additional benefits for their family members? If not,

what would be the incentive to make contributions? If yes, how would discrimination against Medicaid beneficiaries without contributing relatives be prevented?

4. How would the state funds affect the federal-state Medicaid match?

A contribution program which was truly voluntary would have to protect and guarantee the anonymity of donors. In addition, it would have to prohibit the state agency from taking into consideration in eligibility determinations whether contributions were made on the Medicaid recipient's behalf.

If information about contributions became available to the Medicaid agency, the result could be discrimination against Medicaid beneficiaries not having contributing relatives. Medicaid beneficiaries with contributing relatives could be determined to be in need of nursing home care while those without contributing relatives could be found not to be in need of care. This distinction between Medicaid beneficiaries would undoubtedly have a racial impact -- favoring white beneficiaries over black beneficiaries -- and would certainly have an adverse impact on those who have least resources and are least able to care for themselves. The program would also need to be implemented in such a way that eligible Medicaid beneficiaries were not discouraged from applying for benefits -- and receiving necessary care and services -- because of their desire not to burden their relatives. Such safeguards would be essential to ensuring that program beneficiaries and potential beneficiaries were not denied the care and services they need.

The purposes of H.R.7028 can be better achieved by increasing non-institutional alternatives and by creating positive incentives to families to provide care for their elderly members.

H.R. 7028 is apparently intended to reduce the state's expenditures for institutional long-term care and to discourage institutionalization. Relative responsibility laws generally have as their purpose reducing government expenditures for program beneficiaries' care.[5/]

Relative responsibility laws, however, have been discredited as a means of reducing governmental health care expenditures.[6/] Nursing home costs have soared because of a number of factors unrelated to the absence of mandated family contributions. The rising cost of health care is certainly a significant factor as is the aging of our population. (The "old old" are most likely to reside in nursing homes and this segment of our population is rapidly increasing.)

Instead of incorporating the discredited relative responsibility concept into the Medicaid program, Congress should establish incentives that will help families take care of their elderly members.[7/] Respite care, adult day care, day hospitals and other mechanisms that will enable families to get assistance in providing care all need further congressional attention. Similarly, tax credits and deductions for families require further exploration and review.

At the same time, Congress must enact alternative non-institutional ways of providing long-term care to elderly and disabled persons who need services. Congress must reverse the institutional bias in the third party payment programs which make institutionali-

zation the norm and non-institutional care the exception.[8/] Home health care, homemaker chore services and other programs need strengthening to enable older persons to remain in their own homes as long as possible. Such bills as H.R. 6194, the Medicaid Community Care Act of 1980, are a positive step in this direction.

Conclusion

H.R. 7028 attempts to reduce Medicaid expenditures for nursing home care by allowing relatives of institutionalized elderly people to make voluntary contributions to a state fund. The bill is deficient in failing to provide adequate safeguards to ensure that contributions would be voluntary and that Medicaid beneficiaries would not be denied necessary care and services.

In order to achieve H.R. 7028's goals of reducing expenditures for nursing home care, Congress should enact legislation to help families care for their elderly members and to create non-institutional alternatives to long-term care.

69-669 O—80——12

1/ The concept of relative responsibility is not new. Many states have had laws requiring children to support their destitute parents. Enforced by criminal or civil sanctions, these state laws have generally fallen into disfavor and been repealed.

For discussions of the principle of relative responsibility as it relates to long-term care, see Callahan, James J., et al, "Responsibility of Families for Their Severely Disabled Elders," Health Care Financing Review, 29(Winter, 1980) ("Responsibility of Families"); Asford, Joanne P., "Reducing Medicaid Expenditures through Family Responsibility," 5 American Journal of Law and Medicine 59 (Spring, 1979) ("Reducing Medicaid Expenditures.")

2/ Subcommittee on Long-Term Care of the Senate Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy, Introductory Report, S.Rep. 93-1420, 93d Cong., 2d Sess. (1974), p.16.

3/ Id.

4/ About half the residents rely on Medical Assistance as the primary source of payment for their care. National Center for Health Statistics: The National Nursing Home Survey: 1977 Summary of the United States. Vital Health Statistics. Series No. 13 - 42. DHEW Publication No. (PHS) 79-1974. Public Health Service. Washington, D.C. U.S. Government Printing Office July, 1979. p.19, Table 11 (1977 NNHS) Residents relying primarily on there own or their families' income accounted for 38.4% of all residents in 1977. 1977 NNHS, p.99, Table 40. Medicare was the primary payer for a mere 2% of all residents in 1977. 1977 NNHS, p.99, Table 40.

5/ "Responsibility of Families," p.30.

6/ "Reducing Medicaid Expenditures," p.79.

7/ "Responsibility of Families," pp.41-42; "Reducing Medicaid Expenditures," p.72

8/ Comptroller General, "Entering a Nursing Home--Costly Implications for Medicaid and the Elderly" PAD-80-12 (November 26, 1979).

Mr. SHELBY. I appreciate again you all appearing today.

Mr. Tucker and Mr. Harrison. Who is going to testify first?

STATEMENTS OF JOHN B. TUCKER, JR., R. PH., DIRECTOR, GOVERNMENT AFFAIRS, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS; JAMES HARRISON, JR., MEMBER, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. TUCKER. Mr. Chairman, I have a written statement, which I would like to——

Mr. SHELBY. We will submit that for the record, then if you will briefly summarize.

[See p. 182.]

Mr. TUCKER. The National Association of Retail Druggists represents owners and operators of more than 30,000 independent retail drugstores where more than 75,000 pharmacists dispense approximately 70 percent of the prescription drugs sold in America. Our members serve more than 18 million consumers daily.

We respectfully submit that H.R. 7031 is aiming at the wrong target. Prescription drug costs have risen the least of any health service considered by the Consumer Price Index during the past decade.

When title XIX was enacted, the underlying concept was that eligible patients would no longer be treated as second-class citizens. By sublimating this concept to the hope of saving a little money, H.R. 7031 would be inconsistent with medicaid's most basic purpose.

Before medicaid, many independent pharmacists provided medications to indigent citizens without much hope of recouping their costs. At that point, welfare patients constituted between 1 and 2 percent of pharmacists' customers. Title XIX, providing health care to Americans unable to pay for it, was supported by pharmacists. It, in effect, replaced and expanded voluntary efforts of independent pharmacists.

With expansion of medicaid eligibility, many independent pharmacists find from 10 to 15 percent of their customers depend on medicaid for prescription needs. In inner cities, and some rural areas, this figure can easily reach 80 percent of patient load.

Another basic concept behind medicaid was to insure availability of health care to recipients. The independent pharmacist is far and away the most frequently seen health care provider by medicaid recipients. The aged and indigent are not helped by having drugs and services paid for that they are incapable of availing themselves of—due to physical disabilities or lack of transportation.

Even if pharmacists were adequately and promptly reimbursed by medicaid for drugs and services—which they clearly are not—their markets would be obliterated by H.R. 7031. A competitive bidding scheme would effectively reduce health care availability by obliterating the very health care professionals upon whom medicaid recipients depend most—independent pharmacists.

By denying medicaid patients access to the free delivery services offered by many independent pharmacists, problems of inaccessibility would be further exacerbated. Such services are vital to the

elderly and disabled, yet they are seldom provided by chain drugstores and discount, high volume drug retailers.

Currently, 38,000 drugstores provide 70 to 85 percent of the pharmaceutical service to medicaid patients in certain geographical areas. If competitive bidding schemes are put in force, only a few stores will be providing medicaid services, not 38,000. I don't think you intended to create a monopolistic situation in the delivery of pharmaceutical services.

Under the guise of competitive bidding monopolistic situations are created escalating prices in short order. Since the beginning of recorded history, monopolies—whether created by Government or private enterprise—have resulted invariably on higher prices than experienced under open, free enterprise competition. No other industry or profession experiences the degree of competition present in the pharmaceutical area. Allowing single businesses to control prescription drug sales in specified areas will create monopolies, thus destroying the competition currently found.

H.R. 7031 is confusing and unclear on how competitive bidding would be implemented. However, competitive bidding would deny medicaid patients the freedom to choose who provides their pharmaceutical services. Medicaid patients would be treated as second class citizens. The basic concept of medicaid was that no patient would be treated differently from a cash paying customer. No one wants to be treated like a second class citizen.

Competitive bidding would create a situation where medicaid patients are required to use a particular drugstore. The drugstores would be chosen by bureaucrats under the guise of accepting the lowest bid; therefore, medicaid patients would obviously be forced to use a pharmacy that provides no services.

Competitive bidding would probably result in increased medicaid fraud. There would be pressure and temptation to try to buy the medicaid business. Once secured, the winning store might look for ways to increase profits from medicaid prescriptions—reduced services, use unapproved drugs, kickbacks from manufacturers and more. I am sure you don't want to increase the opportunity for medicaid fraud.

Another aspect of H.R. 7031, and it is something that the Department of Health and Human Services has alluded to several times, is volume purchase plans or bulk purchasing.

The National Association of Retail Druggists opposes volume purchase programs placing government—at any level—in competition with free enterprise. Any plan involving establishing State owned warehousing facilities to distribute medications and other health care supplies would be totally unacceptable.

Any volume purchase plan obliging pharmacists to maintain double inventories—one for medicaid recipients and another for regular patients—likewise would be unacceptable, as would any other scheme disrupting established drug distribution systems now serving the health care needs of our citizens.

Volume purchase plans are not explained in H.R. 7031. It is unclear how such programs would be implemented. If States were to try to set up new drug distribution systems, the expense and problems would be astronomical.

The recent White House Conference on Small Business placed strong emphasis on resolutions which would get the government out of any business which competes with small business. Volume purchase plans, which set up new distribution systems would put the Government in direct competition with small businesses.

Volume purchase plans could create a record keeping nightmare for independent retail pharmacists. Keeping inventories separate and transferring merchandise when the medicaid drugs were available, would open a literal Pandora's box; a logistical impossibility.

When such plans involving prescription drugs are analyzed, several problems become obvious:

Will pharmacies be obligated to stock double inventories, one to serve medicaid recipients and one to serve the general public?

Drug selection will be in the hands of untrained, unelected bureaucrats instead of in the hands of physicians and pharmacists qualified to make such selections.

Would States operating drug distribution systems be obligated to assume liability for inappropriate drug selection made by marginally qualified State employees?

Will medicaid recipients be obliged to use ineffective medications over which neither their physicians nor pharmacists have any control?

Will drugs unavailable from State warehouses have to be drawn from pharmacists' inventories?

Will States be forced to spend huge amounts of money for rents, utilities, delivery vehicles, insurance, bookkeeping, billing, labor, security, salaries, and benefits, storage, loading and delivery costs?

We believe there is a better way—there must be. We are in the process of analyzing the problem of lowering overall pharmaceutical costs, not only to recipients of medicaid and medicare, but to the general public as well. We have established the following criteria:

Any cost reduction program should not disrupt the current drug distribution system which has provided our Nation the best health care record in the world;

Medicaid patients must not be relegated to positions of second class citizenship by being denied freedom to select their own health care providers and choose the sources of their prescription drugs and pharmaceutical services the same as any other citizen;

To be acceptable, any cost reduction program should not discriminate against small businness owners nor be detrimental to independent retail pharmacies;

Before being placed into effect nationally, any program under consideration should be tested thoroughly, under the most rigid parameters, for both feasibility and workability on a regional basis, preferably in a single, representative state.

Thank you.

[Testimony resumes on p. 190.]

[Mr. Tucker's prepared statement follows:]

ASSOCIATION OFFICERS
PAUL J. DUMOUCHEL, PRESIDENT
JESSE M. PIKE, PRESIDENT-ELECT
DONALD W. ARTHUR, FIRST VICE PRESIDENT
DON S. KATTERMAN, SECOND VICE PRESIDENT
CHARLES M. WEBB, THIRD VICE PRESIDENT
RALPH P. GUERRA, JR., FOURTH VICE PRESIDENT
JOSEPH A. MOSBO, FIFTH VICE PRESIDENT
D. J. WILLIAMS, SECRETARY-TREASURER

EXECUTIVE COMMITTEE
JOHN A. JOHNSON, CHAIRMAN
NEIL L. PRUITT
JAMES H. VINCENT
JOHN W. WHITE
H. JOSEPH SCHLITTE
LONNIE F. HOLLINGSWORTH

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

EXECUTIVE VICE PRESIDENT • WILLIAM E. WOODS
1750 "K" STREET N.W. WASHINGTON, D.C. 20006
AC 202 347-7486

STATEMENT

JOHN B. TUCKER, JR., R.PH.

DIRECTOR OF GOVERNMENT AFFAIRS

Mr. Chairman, members of the subcommittee. I am John Tucker, director of government affairs, National Association of Retail Druggists.

NARD represents owners and operators of more than 30,000 independent retail drugstores where more than 75,000 pharmacists dispense approximately 70 percent of the prescription drugs sold in America. Our members serve more than 18 million consumers daily. We appreciate being able to present testimony regarding H.R. 7031 and the Medicaid program in general.

We respectfully submit that H.R. 7031 is aiming at the wrong target. Prescription drug costs have risen the least of any health service considered by the Consumer Price Index during the past decade.

The amount being spent by the Medicaid program for prescription drugs and pharmacy services is insignificant when compared to the tax dollars spent in other areas of health care. Money saved by subjecting the pharmaceutical profession to volume-purchasing schemes and competition models involving competitive bidding would be miniscule compared to the ensuing disruption and disorder.

H.R. 7031 WOULD UNDERMINE BASIC MEDICARE/MEDICAID CONCEPTS

When Title 19 was enacted, the underlying concept was that eligible patients would no longer be treated as second-class citizens. By sublimating this concept to the hope of saving a little money, H.R. 7031 would be inconsistent with Medicaid's most basic purpose.

Before Medicaid, many independent pharmacists provided medications to indigent citizens without much hope of recouping their costs. At that point, welfare patients constituted between 1 and 2 percent of pharmacists' customers. Title 19, providing health care to Americans unable to pay for it, was supported by pharmacists. It, in effect, replaced and expanded voluntary efforts of independent pharmacists.

With expansion of Medicaid eligibility, many independent pharmacists find from 10 to 15 percent of their customers depend on Medicaid for prescription needs. In inner cities, and some rural areas, this figure can easily reach 80 percent of patient load.

MEDICATION AVAILABILITY A VITAL CONCERN

Another basic concept behind Medicaid was to ensure availability of health care to recipients. The independent pharmacist is far and away the most frequently seen health-care provider by Medicaid recipients. The aged and indigent are not helped by having drugs and services paid for that they are incapable of availing themselves of -- due to physical disabilities or lack of transportation.

Even if pharmacists were adequately and promptly reimbursed by Medicaid for drugs and services -- which they clearly are not -- their markets would be obliterated by H.R. 7031. A competitive-bidding scheme would effectively reduce health-care availability by obliterating the very health-care professionals upon whom Medicaid recipients depend most -- independent pharmacists.

By denying Medicaid patients access to the free-delivery services offered by many independent pharmacists, problems of inaccessibility would be further exacerbated. Such services are vital to the elderly and disabled, yet they are seldom provided by chain drugstores and discount, high-volume drug retailers.

INDEPENDENT RETAIL PHARMACIES PROVIDE MOST MEDICAID PRESCRIPTION SERVICES

When Medicaid began, there were more than 50,000 independent retail pharmaices in the United States. Medicaid and other third-party programs accounted for 3 to 4 percent of their business. Twenty years later, the number of independents has dropped to approximately 38,000, a 21 percent reduction. Meanwhile, Medicaid and private third-party prescription sales have increased from 20 to 30 percent. The Department of Health and Human Services projects that such sales will reach 75 percent by 1990. Some inner-city areas with large Medicaid populations, and large metropolitan areas covered by private third-party programs, already exceed the 75 percent level projected for 1990. Colorado's independent retail pharmacists fill 85 percent of Medicaid prescriptions in that state, according to a recent compilation released by the State Medicaid Director. This could hold true for several other states.

Currently, 38,000 drugstores provide 70 to 85 percent of the pharmaceutical service to Medicaid patients in certain geographical areas. If competitive bidding schemes are put in force, only a few stores will be providing Medicaid services, not 38,000. I don't think you intended to create a monopolistic situation in the delivery of pharmaceutical services.

Elsewhere, in large metropolitan areas, particularly inner cities having large Medicaid populations, practically the only drugstores left to serve them are independently owned. If these are obliged to close because of inadequate Medicaid reimbursements and third-party payments and their markets are obliterated by volume-purchasing and competitive bidding schemes proposed by H.R. 7031, community pharmacy will be a thing of the past, because chains prove daily they want no part of inner cities unless they are revitalized.

An excellent example of the above situation is Baltimore, Maryland, where 50 percent of the city's independently owned drugstores were forced out of business. The Baltimore areas to which the chains moved are housing complexes that have been renovated. Of course, Medicaid recipients have been forced to leave these renewed areas because they can no longer afford the rent. H.R. 7031 would only serve to make an undesirable situation impossible.

COMPETITIVE BIDDING DEMANDS CLOSE SCRUTINY

According to the Bureau of Labor Statistics, retail drug prices during 1979 rose only 7.3 percent compared to an "all industry" rate of 12.9 percent. This was the direct result of free and open competition in the drug industry.

Under the guise of competitive bidding monopolistic situations are created escalating prices in short order. Since beginning of recorded history, monopolies -- whether created by government or private enterprise -- have resulted invariably in higher prices than experienced under open, free-enterprise competition. No other industry or profession experiences the degree of competition present in the pharmaceutical area. Allowing single businesses to control prescription drug sales in specified areas will create monopolies, thus destroying the competition currently found.

H.R. 7031 is confusing and unclear on how competitive bidding would be implemented. However, competitive bidding would deny Medicaid patients the freedom to choose who provides their pharmaceutical servcies. Medicaid patients would be treated as second class citizens. The basic concept of Medicaid was that no patient would be treated differently from a cash-paying customer. No one wants to be treated like a second class citizen.

Competitive bidding would create a situation where Medicaid patients are required to use a particular drugstore. The drugstore would be chosen by bureaucrats under the guise of accepting the lowest bid; therefore, Medicaid patients would obviously be forced to use a pharmacy that provides no services.

Competitive bidding would probably result in increased Medicaid fraud. There would be pressure and temptation to try to buy the Medicaid business. Once secured, the winning store might look for ways to increase profits from Medicaid prescriptions -- reduced services, use unapproved drugs, kickbacks from manufacturers and more.

Procuring and distributing prescription drugs and pharmaceutical services through competitve bidding presents logistical problems defying description. How will competitively bidding for prescription drugs and and pharmaceutical services work? Will states accept bids for pharmaceuticals and services and select those submitting the lowest-dollar bids? Will Medicaid patients be obligated to patronize Chain Drugstore "A" because it submitted the lowest-dollar bid, even though it has no outlets in inner cities and rural areas? Will independently owned pharmacies, which have well served inner cities and rural areas for years, be forced to take down their signs, close their doors and fade into oblivion because they have no state contracts?

What of Medicaid patients in inner cities and rural areas?

When a state selects Chain Drugstore "A", will Medicaid patients be expected to travel 30, 50 or 100 miles to obtain prescription drugs from Drugstore "A" -- when drugs are available from neighborhood independent pharmacies which may provide free-delivery services?

Daily, reports are being issued by HHS, FDA, Bureau of the Census and other agencies reflecting the escalating numbers of geriatric citizens in America and their ever-increasing need for pharmaceuticals and services. Since many elderly citizens are physically unable, or do not have financial means, to travel the distances which will be required, the logistical problems created for geriatrics alone by H.R. 7031 would negate any savings benefits which might be realized under a competitive-bidding scheme.

Competitive bidding can be likened to exclusive contracts. An example of the disasterous effects of exclusive contracts under the guise of competitive bidding can be found in Denver.

A large health maintenance organization opened in part of Denver. The HMO gave one of the chain drugstores an exclusive contract to provide the HMO patients pharmaceutical services.

In the first year of operation, the HMO contributed significantly to the closing of more than 50 independent retail pharmacies in the area served by the HMO. No doubt, a few of the stores would have closed due to other third party pressures. But such a large number of stores would not have gone out of business if the HMO had not given an exclusive contract to a chain drugstore.

If Medicaid were to utilize exclusive contracts under the guise of competitive bidding, we will watch the demise of most independent retail pharmacies.

VOLUME PURCHASE SCHEMES NO SOLUTION

The National Association of Retail Druggists opposes volume-purchase programs placing government -- at any level -- in competition with free enterprise. Any plan involving establishing state-owned warehousing facilities to distribute medications and other health-care supplies would be totally unacceptable.

Any volume-purchase plan obliging pharmacists to maintain double inventories -- one for Medicaid recipients and another for regular patients -- likewise would be unacceptable, as would any other scheme disrupting established drug-distribution systems now serving the health-care needs of our citizens.

Volume-purchase plans are not explained in H.R. 7031. It is unclear how such programs would be implemented. If states were to try

to set up new drug distribution systems, the expense and problems would be astronomical.

The recent White House Conference on Small Business placed strong emphasis on resolutions which would get the government out of any business which competes with small business. Volume-purchase plans, which set up new distribution systems would put the government in direct competition with small businesses.

Volume-purchase plans could create a record-keeping nightmare for independent retail pharmacists. Keeping inventories separate and transferring merchandise when the Medicaid drugs were available, would open a literal Pandora's box; a logistical impossibility.

When such plans involving prescription drugs are analyzed, several problems become obvious:

-- Will pharmacies be obligated to stock double inventories, one to serve Medicaid recipients and one to serve the general public?

-- Drug selection will be in the hands of untrained, unelected bureaucrats instead of in the hands of physicians and pharmacists qualified to make such selections.

-- Would states operating drug-distribution systems be obligated to assume liability for inappropriate drug selection made by marginally qualified, state employees?

-- Will Medicaid recipients be obliged to use ineffective medications over which neither their physicians nor pharmacists have any control?

-- Will drugs unavailable from state warehouse have to be drawn from pharmacists' inventories meant for dispensing to the general public? Nightmarish control and inventory problems will result for everyone involved, aside from increased opportunity for fraud which would be generated.

-- Will states be forced to spend huge amounts of money for rents, utilities, delivery vehicles, insurance, bookkeeping, billing, labor, security, salaries and benefits, storage, loading and delivery costs? These expenses are currently borne by wholesalers and manufacturers' point-of-purchase facilities. To expect government to assume these burdens, at less expense than the private sector, is, at best, naive.

IS THERE A BETTER WAY?

We believe there is a better way -- there must be. We are in the process of analyzing the problem of lowering overall pharmaceutical costs, not only to recipients of Medicaid and Medicare, but to the general public as well. We have established the following criteria:

-- Any cost-reduction program should not disrupt the current drug-distribution system which has provided our nation the best health-care record in the world;

-- Medicaid patients must not be relegated to positions of second-class citizenship by being denied freedom to select their own health-care providers and choose the sources of their prescription drugs and pharmaceutical services the same as any other citizen;

-- To be acceptable, any cost-reduction program should not discriminate against small-business owners nor be detrimental to independent retail pharmacy;

-- Before being placed into effect nationally, any program under consideration should be tested thoroughly, under the most rigid parameters, for both feasibility and workability on a regional basis, preferably in a single, representative state.

FIXED FEES

Today, even without volume-purchasing and competitive bidding, there are many problems confronting independent pharmacists servicing Medicaid patients. Fixed dispensing fees -- inadequate to begin with -- are based on out-of-date information. To subject pharmacists to volume buying and competitive bidding at this point will serve only to create more chaos and confusion in an already terse Medicaid system. These problems are so extensive that further restrictive actions could easily destroy the entire Medicaid concept. Problems being experienced in Alabama, Pennsylvania, Georgia and West Virginia could become nationally pervasive.

States reimburse pharmacists on a product-cost plus fixed-dispensing-fee basis. Fees are determined by state Medicaid agencies. States are required by regulations to conduct surveys of costs of filling prescriptions; but, since they are not required to use the survey data, states can establish fixed dispensing fees at whatever rate they choose. So far, fixed fees have always been below the average dispensing cost.

When states do make required surveys, the data are obviously 12 months old when collected. By the time they are analyzed, they are a

minimum of two years old. By the time states get around to granting fee increases, the data are three years old. It is not rare for dispensing fees to be three years out of date by the time increases are granted, even if based on a required survey.

Further, services provided Medicaid patients are not paid for by Medicaid. Services such as 24-hour emergency prescription service, free delivery, maintenance of patient profiles and consultations are of no intrinsic value where Medicaid is concerned. Yet, Medicaid patients expect and depend upon these services, the same as cash-paying customers. Additionally, states never consider reasonable profits or returns on investment. By not including compensation for investments pharmacists have in inventories, fixtures and buildings in these days of exhorbitant interest rates, the fixed dispensing fee becomes a luxury that many pharmacists cannot afford.

Few states grant annual fee increases to pharmacists. Considering the rate of inflation over the past 10 years, pharmacists are in serious trouble.

Another problem with the Medicaid program is inadequate state fees. When states prepare annual budgets, anticipating providing increased fees to pharmacists, additional funds allocated for possible fee increases are usually used up by increases in wholesale costs of drug products.

Manufacturers can raise their prices at will. What happens when a manufacturer raises his price? Generally, a letter is sent to pharmacists stating that prices today went up 10 percent. If the pharmacist has to order the medication the next day, the new price is 10 percent higher.

Because states are slow in changing their records, new wholesale prices are not reflected in the states' computers for 30 to 90 days. Therefore, if there is a 10 percent increase (say price of a product goes from $10.00 to $11.00 per 100 tablets) and the pharmacist fills the prescription for 100, with a $2.50 fee, the pharmacist has lost $1 because the state has not changed its computer records. In effect, the pharmacist gets a fee of $1.50, not $2.50.

When states do change their records updating drug prices, money previously allocated for their Medicaid programs is used up quickly. Nothing is left to increase pharmacists' dispensing fees and they are left with fee schedules that may be one to six years out of date.

MAXIMUM ALLOWABLE COST

The Health Care Financing Administration, trying to reduce prescription costs, has placed regulations in effect under the Maximum Allowable Cost program (MAC) and the Estimated Allowable Cost (EAC). The MAC program is 10 years too late.

In today's market, considering the number of generics available, and the required drug-substitution laws effective in many states, the MAC program is ineffective or unneeded.

Another problem with the EAC and MAC is they offer no incentive for pharmacists to save on procurement. They are penalized for buying in quantity to obtain lower prices, since they do not share in the profits resulting from quantity-buying. A pharmacist could invest money to buy in larger quantities to save his customers money while making profit, but, MAC and EAC prevent this from happening with Medicaid. So why should pharmacists buy in larger quantities?

SLOW, INADEQUATE REIMBURSEMENT

After pharmacists fill prescriptions and submit claims to the state, they must wait for reimbursement. HCFA has promulgated regulations requiring states to pay 90 percent of all "clean" claims within 30 days. However, since these regulations have no enforcement provisions, if a state either does not want to, or cannot -- because of budget problems -- reimburse the pharmacist in a timely fashing as required by regulations, reimbursements can be delayed indefinitely or forgotten.

When a state runs out of money, as a number of states have, such as Alabama, pharmacists are being asked to continue underwriting the Medicaid system until money becomes available. Medicaid was not designed to be a charity for states. It was designed to provide health care to those families who cannot afford it and allow reasonable profits to providers of Medicaid services.

Reimbursement rates today are well below what they should be. It is difficult to stay in business when you are losing 25¢ on every prescription. These problems are not restricted to Medicaid. Private, third-party prescription programs follow in Medicaid's footsteps. Whatever Medicaid gets away with the private carriers do too. Therefore, pharmacists are being used as "whipping boys", with fees kept far below what that should be if independent pharmacists are to stay in business.

Mr. Chairman, apparently Health Care Financing Administration bureaucrats are totally unaware of how competitive retail pharmacy really is. Other segments of the health-care system are not competitive at all. However, in the retail pharmacy business, if your prices are too high, consumers go down the street to a chain drugstore or another independent. If chain prices are too high, consumers will patronize the independant. Because drugstores are conveniently located in neighborhoods as stated before, we are the health-care professionals most often seen by patients. Despite this, all of the problems being created by Medicaid continue to reduce the number of independent pharmacies in business.

- more -

In lieu of passing H.R. 7031, to create more problems for the Medicaid program, HARD urges passage of legislation requiring states to pay market place prices for prescription drugs.

Marketplace prices would enable pharmacies to be reimbursed for the services and products supplied. Medicaid patients would benefit because more independent pharmacies would remain in business. The government would save money.

The amount being spent by Medicaid for prescription drugs and pharmacy services is insignigicant when compared to tax dollars being spent in other areas of health care. Money saved, if any would be by subjecting the pharmaceutical profession to volume-purchasing schemes and competition models involving competitive bidding would be miniscule compared to the disruption and disorder which would be experienced.

Mr. SHELBY. Thank you.

Mr. Harrison.

Mr. HARRISON. Mr. Chairman, my statement reemphasizes some of the same points Mr. Tucker has made. It is a short statement. Would you like for me to read it?

Mr. SHELBY. Summarize it if you want to.

STATEMENT OF JAMES HARRISON, JR.

Mr. HARRISON. Mr. Dannemeyer and Mr. Shelby, my name is Jim Harrison, Jr. I am a registered pharmacist and chief executive officer of Harco Drug, a chain of 45 retail drugstores operating in the States of Alabama and Mississippi. I want to thank you, first of all, for the opportunity to express my thoughts to you in regard to H.R. 7031, a competitive bidding proposal that would pertain to the medicaid program.

I would also like to mention that I am a member of the board of directors of the National Association of Chain Drug Stores (NACDS) and that my statement today is presented in behalf of this organization. NACDS represents more than 194 corporations managing more than 12,000 drugstores and 1,500 leased pharmacies throughout the United States. In total, the chain drug industry is responsibile for providing nearly 40 percent of the Nation's outpatient prescription drug needs and our industry has a very strong rate of participation in the medicaid program.

I woud say that I am very much aware, and in full sympathy, with what my friend, Congressman Richard Shelby is trying to accomplish with this legislation. You could hardly live in the State of Alabama, with all the medicaid problems we have had, and not understand what the Congressman is endeavoring to achieve.

While I recognize there may be a genuine need for this type of legislation so that States like Alabama, that are experiencing financial difficulties will be better able to control their medicaid costs, it is our opinion that to include prescription drugs under a competitive bidding program would be unwise and inappropriate. I will try to outline the reasons for that statement.

First of all, are there savings to the States to be realized? It is our belief that the savings would be minimal at best.

Consider that we are talking about a section of the medicaid program that in the State of Alabama last year called for only about 7 cents of each medicaid dollar.

Consider that we are also talking about an industry already governed by a federally mandated maximum allowable cost pro-

gram which sets price reimbursement limitations for drug products, both general and brand name, that are provided under Federal health care programs such as medicaid.

Consider that we are talking about an industry in which prices rose only 7.5 percent in 1979 while other health care costs, such as physicians fees and hospital costs, soared much higher in comparison.

Then consider the costs to the States of monitoring and managing this program. This has been played down by proponents of the legislation and to play it down is unrealistic. There will be considerable accounting and management costs involved. Costs, that in themselves alone, could negate much of the savings hoped for by this bill.

Second, this legislation will have an inflationary effect on the price of prescription drugs to nonmedicaid patients.

Pharmacies participating in the program would have to carry two separate inventories of drugs—their own and a State inventory. The additional recordkeeping, billing, administrative, and ordering responsibilities created would substantially increase the costs of operation for the pharmacy. These costs will have to be passed on to the consumer—the nonmedicaid consumer. Unless the bill would require the program to pay for these additional costs.

In line with the inflationary effect of the legislation, chain pharmacies, such as Harv[illegible] would lose important buying power for those drugs covered under the program. We are fearful that it will mean a loss of volume discounts which will result in higher costs to the pharmacy for drugs in general. And, of course, a higher cost to the pharmacy would mean a higher cost to the consumer, again, the nonmedicaid consumer.

I don't think there is any question that the nonmedicaid consumer would have to pay for part of the program, but under this legislation he would be supporting medicaid twice—with his taxes and when he purchases his prescriptions.

Third, the legislation would set up a double standard of health care.

Under the present system the medicaid patient is accorded the same level of care available to any other patient. Under the proposed system many quality drugs would be eliminated because they were not selected through the State's low bid program. The medicaid patient would be restricted to those pharmaceuticals approved by the State's program. The professional discretion of the physician and the pharmacist would bow to the State's selection of drugs, based on the lowest bid price. To limit substitution and the availability of quality prescription drug products would not be a very prudent move, in our opinion.

Fourth, the legislation would tend to curtail the present smooth flow of drugs to the ultimate consumer.

I feel that the possibility exists that a substantial number of pharmacies would drop out of the program rather than labor under the constraints and costs incurred by a double inventory and the extensive bookkeeping requirements that the legislation would create. This would be disastrous in the States of Alabama and Mississippi as it would certainly leave many recipients without access to a pharmacy and a source of medication in many of the

small communities in the State. My home State cannot be that much different from the States you gentlemen represent. I am sure you can appreciate the possible problem involved here.

Additionally, with a limited number of approved drugs you sacrifice great flexibility and interrupt the smooth flow of prescription drugs to the consumer. If you are out of a particular medication, for whatever reason, you can, under the present system utilize another company making the same drug and take care of the patient's needs. Under the proposed system this flexibility is lost, the patient will be without his medication until a new supply can be restocked.

And finally, gentlemen, in light of the strong tone at this time within the Congress to minimize the growth of Government, to deregulate wherever possible and to allow the forces of the marketplace to function effectively and efficiently in the best interests of the consuming public, we believe that to include prescription drugs for competitive bidding purposes would be a drastic mistake and a giant step backward.

I thank the subcommittee again for the time allotted to me, for your attention and I seriously urge the subcommittee to carefully consider the points that I have made in this statement.

Mr. SHELBY. Mr. Harrison, if we excluded prescription drugs in the competitive bidding process, if we were ever able to pass legislation such as this now or later, and it is late in the season now, we all realize that, what would competitive bidding be in order for? In other words, what about other things other than prescription drugs? You are in the drug business, you have 45 drugstores, have you got some suggestion?

Mr. HARRISON. Well, Mr. Shelby, I only have the expertise in this field. I can see what you are trying to do and I can see where Mr. Dannemeyer, or someone mentioned they thought legislation of this type, the time had come for it, and I feel that that is true. The shotgun approach is what I am in opposition to, because I can see how it would affect my particular industry and it would be an adverse effect.

But I do think what you are trying to accomplish is very meaningful and needful, especially in our State.

Mr. SHELBY. Of course, one of the problems that I have reservations on, and we get into hearings and that is why we have them, is how would you implement such a thing as competitive bidding for prescription drugs. In other words, like Dr. White mentioned this morning—who is a State senator and pediatrician in Birmingham—would it call for setting up another bureaucracy to entertain that and to carry it out? If that is going to have to happen, there is no merit in it at all. If it is going to in the long run cost the consumer, the recipient of those services more, then there is no merit in it.

I just thought I would throw that out. We all have certain reservations about different things and like I said this morning, I told Chairman Waxman that I appreciated him having these hearings. Here it is coming up the middle of September nearly, and it is late in the game, but like my colleague from California said earlier, sooner or later there is going to have to be a day of reckoning on the growth of the medicaid program.

best copy available

How do you stop? In other words, you don't want to stop. I certainly don't. You don't want to cut off somebody who needs help, whether they are old or young. Who wants to do that? I know you don't. I know you personally, I know you have probably given away a lot of drugs and your family over the years, to people who didn't have any money. We all have some compassion. But dealing from a legislative standpoint, we have got to come up with ideas. Maybe you gentlemen have some.

Mr. HARRISON. Mr. Chairman, the only thing I would like to reiterate, I think it would be a mistake to get the Government more involved in private enterprise. Based on how I interpret this bill, if it leans that way, then I don't think that is the answer, although I agree with you answers are needed.

Mr. SHELBY. OK.

Mr. Dannemeyer.

Mr. DANNEMEYER. I have no questions.

Mr. SHELBY. Gentlemen, do you have anything to say?

Mr. TUCKER. Yes, sir. I would like to compliment you on the fact you talked about having the hearing, even though it is late in the legislative season. As Dr. Davis said earlier, and also Mrs. Harris testified before your subcommittee and in the Senate, HHS is looking very strongly at competitive bidding and volume purchase plans, I don't think they have fully thought out the ramifications of these programs and the hearings you have had, have brought up some of the real problems particularly pharmacists will face if they don't think——

Mr. DANNEMEYER. Let me explore one thing. I have one thought here that I want to make sure I understand correctly. Your concern is that, if for instance, people in the drugstore business entered into a competitive bidding arrangement, the successful bidder would then be selling drugs at a certain rate for a certain region, which might result in a shortage for consumers who would have to travel to the location of the successful bidder's business.

I don't know, I have traveled very little in Alabama—that is my loss. But I have traveled a little in my home State of California and it is getting to the point, in the Orange County area, 30 miles from Los Angeles, that the traffic and the cost of fuel is enough to make people think twice before driving 10 miles. If the person in the drug business who had won the contact was 10 miles away, it would be quite a chore for a consumer to reach him or her.

Mr. SHELBY. That is what I was just thinking about is how would you implement different things. That is, I will tell the gentleman from California and the others, we introduced these bills because we had an acute situation and I am sure we will continue to have in the future, unless something is done about it, in Alabama and they asked us to come to Washington, give us help and so, being a member of the Health committee I introduced the bills and other members of the Alabama delegation joined with us in cosponsoring the bills to give us a hearing.

Senator Heflin, along with Senator Stewart introduced the same bills in the U.S. Senate, and what we want to do is find a remedy, find a resolution to the problems. I know it is very complex, as you pointed out, you know it sounds good, I guess on paper to say well, let's put out for competitive bidding, then like the gentleman from

California says, you are 10 miles from where you can get it filled and that doesn't solve the problem, as the gentleman points out.

Mr. DANNEMEYER. Was your concern here that you expressed——

Mr. TUCKER. That is one of the concerns. We have seen it, an exclusive contract situation took place with an HMO, where they gave one particular chain drugstore a contract. Of course, obviously other chain drugstores in the area didn't have any of the HMO business, the independents didn't have any of the business in the area, and over 50 stores have closed in the first year. It was a very large HMO. That example can be transferred into a medicaid situation if they go to that type of competitive bidding.

Mr. SHELBY. Along the same lines, maybe on a larger scale, we as legislators and you in the business of providing services to recipients of drugs, have got to consider the aging of our population in this country, the demographic study, to see were it is going. You know well in southern California how the people are going to get around to fill prescriptions, to go to the doctors, to do all these things.

It is a complex problem, gentlemen. I appreciate your coming here today and waiting all day to testify. We had a lot of people. Thank you.

Mr. TUCKER. Thank you.

Mr. HARRISON. Thank you.

[The following statements and letter were received for the record:]

AMERICAN HOSPITAL ASSOCIATION
444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 202-638-1100
WASHINGTON OFFICE

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE
HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE
ON H.R.7031, A BILL TO AMEND TITLE XIX OF THE SOCIAL SECURITY ACT
TO ALLOW STATES TO PROVIDE FOR COMPETITIVE BIDDING
FOR THE PURCHASE OF CERTAIN ITEMS UNDER THEIR MEDICAID PLANS
September 23, 1980

The American Hospital Association, on behalf of its 6,100 institutional and 30,000 personal members, is pleased to offer its comments on H.R.7031, a bill to revise the "freedom of choice" provisions of Title XIX of the Social Security Act.

Although certain aspects of the bill are somewhat vague, we understand that its intent is to permit state Medicaid plans to purchase certain items or services through competitive bidding or other arrangements. These items and services would include:

- non-hospital laboratory and x-ray services
- family planning supplies
- prescription drugs
- prosthetic devices, dentures, and eyeglasses

The bill would require that competitive bidding arrangements satisfy three conditions, as determined by the Secretary of Health and Human Services: (1) that adequate services would be available; (2) that the providers of such services would meet requirements otherwise imposed for the provision of such services under the state plan; and (3) that charges for such services would be made at the lowest rate charged for comparable services by the provider.

AHA COMMENTS AND CONCERNS

The American Hospital Association believes that there are certain significant questions related to the accessibility and quality of services that must be answered before competitive bidding arrangements are sanctioned for widespread use in the Medicaid program. Demonstration projects should be undertaken to provide documentation in support of the formal changes in the Medicaid statute proposed by H.R.7031.

Freedom of Choice under Medicaid

Section 1902(a)(28) of the Social Security Act was designed to assure that any individual eligible for Medicaid is able to obtain the services available under his or her state plan from any institution, agency, pharmacy, person or organization qualified to provide such services. Many considerations led to the initial adoption of this provision, the foremost being the desire to avoid a dual system of health care in which the poor would be channelled into service settings different from those available to persons able to pay. In such a dual system, improvements in the quality of services available in the "mainstream" would not emerge as rapidly in the secondary health care system, creating a distinction in the quality of services available to the poor. In addition, a two-tiered system would encourage the diversion of resources into the more affluent tier, resulting in an eventual decline in the accessibility of services to the poor. And, finally, a two-tiered system would create second-class status for those who have no alternative to publicly-funded benefits.

Since its enactment, the "freedom of choice" provision in Medicaid has received strong support from both the Congress and the courts. However, some states have criticized the broad application of the provision as an interference with their abilities to adopt cost-saving arrangements for the program. They contend that "freedom of choice" was meant to be applied only to services for which the patient ordinarily chooses the provider. Some services, such as provided by clinical laboratories outside the hospital setting, do not fall into this category.

From time to time, various proposals for demonstration projects to provide certain services through competitive bidding have come before the Congress. For example, Section 258 of H.R.934, would authorize states to purchase laboratory services (for a three-year experimental period) and medical devices for their Medicaid populations through competitive bidding or other arrangements. Similarly, Section 26 of H.R.4000, as reported by this Subcommittee, would authorize states to purchase laboratory services on a three-year trial basis through competitive bidding. (The latter provision is also found in Section 324 of H.R.7765, the Omnibus Reconciliation Act of 1980.) H.R.7031, however, would enlarge this concept, proposing permanent changes in the Medicaid law of a similar nature.

Potential Problems with Competitive Bidding and Negotiated Arrangements

The AHA believes that certain significant questions must be answered before competitive bidding arrangements are sanctioned for widespread use in the Medicaid program. These questions include:

- How will emergencies be handled if the low-bid provider is not available on a 24-hour basis?
- How will physicians and hospitals be kept advised about the availability of approved service/item providers?
- Is it appropriate, within the intent of the law, for states to become direct distributors or providers of services?
- What measures will be used to evaluate the "adequacy" and availability of services under these arrangements?
- To what extent will competitive bidding incentives affect quality over the long run?
- Even if accessibility is not an issue, to what extent should patient convenience be considered in providing Medicaid services?

The AHA does not believe there is sufficient documented information for either the public or private sectors to answer these questions at this time.

Recommendation

The American Hospital Association believes that the potential for alternative arrangements for the provision of certain Medicaid services should be explored. However, because significant questions remain unanswered, we believe it is imperative that demonstration projects be undertaken to evaluate the effect of such arrangements on the cost, quality, and accessibility of Medicaid services and to provide documentation in support of formal changes in the Medicaid statute, such as those proposed by H.R.7031.

We caution that it would not be appropriate to expand the scope of such arrangements to include inpatient and outpatient hospital services. As noted, considerations of freedom of choice, accessibility, and quality, which the original Medicaid legislation sought to preserve, dictate that competitive and negotiated arrangements be limited to services that the patient ordinarily does not choose or to products that ordinarily are not differentiable in quality.

The American Hospital Association appreciates your attention to our comments. We would be pleased to provide any additional comments or information that the Subcommittee may desire.

Statement of the American Pharmaceutical Association

The National Professional Society of Pharmacists

TO THE U. S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HEARING ON
MEDICAID COMPETITIVE BIDDING
SEPTEMBER 8, 1980

American Pharmaceutical Association
2215 Constitution Avenue, N.W.
Washington, D.C. 20037

(202) 628-4410

THE AMERICAN PHARMACEUTICAL ASSOCIATION WISHES TO EXPRESS ITS OPPOSITION TO THE PROVISION IN H.R. 7031 WHICH LEGISLATIVELY AUTHORIZES STATE MEDICAID PROGRAMS TO PROVIDE FOR COMPETITIVE BIDDING FOR THE PURCHASE OF PRESCRIPTION DRUGS.

UNDER THIS BILL, STATES WOULD APPEAR TO HAVE THE LATITUDE TO IMPLEMENT COMPETITIVE BIDDING PROGRAMS IN ANY NUMBER OF WAYS, INCLUDING:

- DIRECT PURCHASE OF DRUGS BY THE STATE AND DISTRIBUTION BY THE STATE TO PHARMACIES, WITH THE PHARMACIES HAVING TO MAINTAIN TWO SEPARATE DRUG INVENTORIES -- ONE FOR MEDICAID PATIENTS AND ONE FOR ALL OTHER PATIENTS; OR
- COMPETITIVE BIDDING AMONG MANUFACTURERS OR WHOLESALERS, WHO WOULD THEN DISTRIBUTE DRUG PRODUCTS TO PHARMACIES; OR
- COMPETITIVE BIDDING AMONG PHARMACISTS.

MOST OF THE DISCUSSION CONCERNING COMPETITIVE BIDDING AND VOLUME PURCHASING OF DRUGS HAS CENTERED AROUND POTENTIAL SAVINGS. BUT, IT IS IMPORTANT TO NOTE THAT IF A HYPOTHETICAL PROGRAM SAVINGS OF 20% ALSO INVOLVES A 25% ADMINISTRATIVE COST, THE NET EFFECT IS ESCALATION OF THE TOTAL PROGRAM COSTS.

WE HAVE YET TO SEE AN ACCURATE ANALYSIS AND PROJECTION OF THE ADMINISTRATIVE COSTS ASSOCIATED WITH A STATE COMPETITIVE BIDDING PLAN. OUR PAST EXPERIENCE WITH OTHER PROGRAMS IS THAT THE PROJECTED SAVINGS ARE ALWAYS OVERSTATED AND PROJECTED ADMINISTRATIVE COSTS UNDERSTATED.

IF STATES WERE TO IMPLEMENT SUCH A PROGRAM, HERE ARE SOME OF THE POTENTIAL PROBLEMS:

- THERE WOULD BE INCREASED BUREAUCRACY AND PAPERWORK FOR THE STATES. STATES WOULD HAVE TO WRITE AND ISSUE DETAILED REQUIREMENTS AND REQUESTS FOR BIDS FROM WHATEVER NUMBER OF SUPPLIERS OR PROVIDERS IS NECESSARY TO PROVIDE SERVICE TO ALL MEDICAID BENEFICIARIES THROUGHOUT THE STATE. THEY WOULD HAVE TO SOLICIT, REVIEW AND AWARD BIDS, ABIDING BY DUE PROCESS CONSIDERATIONS. APPEALS FROM UNSUCCESSFUL BIDDERS WOULD HAVE TO BE REVIEWED AND ADJUDICATED.
- THERE MAY BE INVENTORY CONTROL AND MANAGEMENT PROBLEMS, AND PROBLEMS OF QUALITY ASSURANCE.

SOME STATES MIGHT SET UP A DRUG PURCHASING, WHOLESALING, WAREHOUSING AND DISTRIBUTING SYSTEM, AT GREAT COST TO THE STATE, DESPITE THE FACT THAT THIS SYSTEM WOULD BE DUPLICATIVE OF THE EXISTING SYSTEM IN THE PRIVATE SECTOR.

THE BOTTOM LINE IS THAT THE ADMINISTRATIVE COSTS OF COMPETITIVE BIDDING FOR MEDICAID PRESCRIPTION DRUGS COULD RESULT IN OVERALL PROGRAM COST INCREASES, RATHER THAN THE ANTICIPATED DECREASES.

INCLUDING PRESCRIPTION DRUGS IN H.R. 7031 COULD ALSO HAVE POTENTIAL NEGATIVE IMPACT ON THE PROGRAM'S BENEFICIARIES. BIDDING AMONG PHARMACIES WOULD HAVE THE DIRECT RESULT OF REDUCING THE NUMBER OF PHARMACIES PARTICIPATING IN MEDICAID. THIS COULD CREATE ENORMOUS PROBLEMS FOR PATIENTS, PARTICULARLY IN RURAL AREAS.

IF PHARMACISTS ARE REQUIRED TO BID ON THE PROVISION OF MEDICAID SERVICES, OR TO MAINTAIN SEPARATE DRUG INVENTORIES, OR TO ADD MORE PAPERWORK BURDENS TO THEIR ALREADY SIGNIFICANT MEDICAID ADMINISTRATIVE COSTS, MANY PHARMACISTS MAY FIND THEY CANNOT AFFORD TO CONTINUE TO PARTICIPATE. IF GROWING RANKS OF PHARMACISTS INDIVIDUALLY DECIDE THEY CAN NO LONGER PARTICIPATE IN MEDICAID, THIS WOULD GREATLY REDUCE PATIENTS' CONVENIENCE OF ACCESS TO PHARMACY SERVICE. THIS WOULD ALSO HAVE THE EFFECT OF LIMITING OR RENDERING NONEXISTENT THE MEDICAID PATIENT'S RIGHT TO FREEDOM OF CHOICE IN THE SELECTION OF A PHARMACIST.

OTHER POTENTIALLY NEGATIVE IMPACTS ON MEDICAID PATIENTS INCLUDE LACK OF ACCESS TO NEEDED DRUGS IF THE SYSTEM FAILS TO PERFORM, AND LIMITATIONS ON THE SOURCES OF DRUG PRODUCTS AVAILABLE UNDER MEDICAID SO THAT THE PATIENT MAY BE DENIED A SPECIFIC DRUG PRODUCT WHICH IS DEEMED MEDICALLY NECESSARY TO MEET THAT PATIENT'S INDIVIDUAL NEEDS.

THE AMERICAN PHARMACEUTICAL ASSOCIATION RECOGNIZES THAT PUBLIC FUNDS MUST BE SPEND PRUDENTLY. HOWEVER, WE FEEL IT IS UNLIKELY THAT ANTICIPATED SAVINGS FOR THE PUBLIC WOULD BE REALIZED UNDER A STATE-RUN COMPETITIVE BIDDING PROGRAM.

A BETTER SOLUTION LIES IN REDUCING THE STATE'S ALREADY SIGNIFICANT MEDICAID ADMINISTRATIVE COSTS. FOR EXAMPLE, THE AMERICAN PHARMACEUTICAL ASSOCIATION HAS LONG SUPPORTED USE OF A VOUCHER PAYMENT SYSTEM WHICH WOULD NOT ONLY RESULT IN PROMPT PAYMENT FOR SERVICES BY PHARMACISTS, BUT ALSO COULD SIGNIFICANTLY REDUCE THE STATE'S ADMINISTRATIVE COSTS OF PROCESSING MEDICAID CLAIMS. ALABAMA INITIATED SUCH A SYSTEM YEARS AGO, AND IT WAS OUR UNDERSTANDING THAT IT WORKED VERY WELL, BEFORE THE STATE ABANDONED IT IN FAVOR OF A MORE COSTLY SYSTEM.

A FURTHER RESULT OF INCLUDING PRESCRIPTION DRUGS IN H.R. 7031 WOULD BE THE CREATION BY THE STATE OF MONOPOLIES IN FAVOR OF LARGE VOLUME PURCHASERS AND SELLERS OF PRODUCTS. THE EFFICIENT DRUG DISTRIBUTION SYSTEM WHICH WE NOW HAVE IN THIS COUNTRY COULD FIND ITSELF BOGGED DOWN IN AN ADMINISTRATIVE MORASS. AND, RATHER THAN REDUCING COSTS, THE STATE'S MEDICAID ADMINISTRATIVE COSTS WOULD LIKELY INCREASE.

THE AMERICAN PHARMACEUTICAL ASSOCIATION URGES THIS SUBCOMMITTEE TO STRIKE FROM H.R. 7031 THE PROVISION AUTHORIZING STATE MEDICAID PROGRAMS TO IMPLEMENT COMPETITIVE BIDDING FOR THE PURCHASE OF MEDICAID PRESCRIPTION DRUGS.

AMERICAN DENTAL ASSOCIATION

WASHINGTON OFFICE • SUITE 1004 • 1101 17TH STREET N.W. • WASHINGTON D.C. 20036 • PHONE 202/833-3630

September 23, 1980

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health and Environment
Committee on Interstate and Foreign Commerce
2415 Rayburn House Office Building
Washington, D. C. 20515

Dear Mr. Waxman:

The American Dental Association appreciates this opportunity to comment on H.R. 7031, proposed legislation that would allow states to provide for competitive bidding for the purchase of certain items under their medicaid plans. We ask that this letter be included in the record of the hearings on this and similar bills.

The Association realizes the intent of this legislation is to effect a cost savings in state Medicaid programs by securing certain services or products at the lowest possible expenditure. What is of specific concern to the Association is the provision that would allow for the purchase of dentures, along with laboratory and x-ray services, family planning supplies, prescription drugs, prosthetic devices and eyeglasses through a competitive bidding process. While perhaps some of these health related services or products can be generally purchased or obtained on a prescription or similarly authorized and standardized basis, dentures are not and cannot be dispensed in a like manner. Considerably more so than any of the other services or products identified in the legislation, the final provision of dentures is the end result of a careful review of the patient's total health needs. Dentures must be customized and fitted to the individual patient, thereby precluding a uniform "formula" to be applied as would be required for products purchased in a competitive bidding situation.

The denture itself is a prosthesis which intimately interacts with the constantly changing, living tissue of the mouth, jaws and skull. Bone structures, musculature, and the soft tissue must work in concert with a denture to permit the patient to masticate, speak and appear as normal as possible without his natural teeth. When properly constructed

and fitted, a denture establishes and maintains a complex relationship with other bodily functions essential to good health. One example relates to the temporomandibular joint, areas in the base of the skull which support the lower jaw. Improperly constructed dentures can lead to joint dysfunction, pain, and possibly the impairment of hearing.

To provide the patient with successful denture treatment, there are several critical, biologically oriented steps that must occur prior to and immediately following the actual insertion of the prosthesis; (1) proper diagnosis, (2) treatment of any existing conditions before insertion of a denture can be considered, (3) the taking of accurate impressions, (4) assessment of the relationship of the denture to the upper and lower jaws and the temporomandibular joint, (5) proper insertion and personalized instructions to the patient and (6) necessary adjustments and follow-up care.

As such, the mechanical, health product aspect of dentures cannot override the anatomic, physiological and psychological considerations which comprise total denture treatment.

The Association believes that providing for the purchase of dentures in the manner suggested in the legislation does not best serve the health of the Medicaid patient. The denture cannot be separated from the biologically complex health care service of which it is a part. The Association urges that the provisions in the legislation regarding the purchase of dentures through a competitive bidding process be deleted from the proposed legislation, in light of the complex factors involved in comprehensive denture treatment. The American Dental Association would be pleased to participate in any further discussions on this issue.

Thank you for your consideration of our views.

Sincerely,

Wilfred A. Springer

Wilfred A. Springer, D.D.S.
Chairman
Council on Legislation

WAS:cs

[Whereupon, at 3:25 p.m., the hearing was adjourned.]

○